The drug crisis : report on drug abuse in Illinois to the Illinois General Assembly.

The Drug Crisis

Report on Drug Abuse in Illinois

Illinois Legislative Investigating Commission
October 1971

Illinois Legislative Investigating Commission
300 W. Washington St., Chicago
Telephone 312-726-6765

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To the Illinois General Assembly
By the Illinois Legislative Investigating Commission
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ACKNOWLEDGEMENTS

We wish to express our gratitude to Senators Cecil A. Partee and Albert F. Bennett, former Commissioners, for their invaluable contribution to our investigation of the drug crisis. Their diligent work on behalf of our undertaking was much appreciated.

Our greatest thanks is extended to the Commission's staff for their several thousand hours of research and writing. In this regard we would like to single out the efforts of our Executive Director, Charles Siragusa, whose thirty years of dedicated service in the war against drug abuse did much to shape our investigation, legislation, and Report. We wish also to thank our Chief Counsel, Roger C. Nauert, for his splendid efforts and creativity in drafting the Commission's drug legislation and this encyclopedic Report. Lastly, we would also like to commend Assistant Counsel Daniel J. Lenckos for his redoubtable work in connection with the research and draftsmanship which went into these works.

We are also indebted to the Illinois State Police and the Attorney General of Illinois for contributing the efforts of Captain Clyde W. Oliver, Jr., and Corporal Christian R. Maerz in supplying many of the photographs appearing in this Report.

Included in this Report is a copy of an excellent reference booklet "Drugs of Abuse" furnished to us, on a cooperative basis, by Mr. John E. Ingersoll, Director, United States Bureau of Narcotics, Washington, D. C. This booklet describes the various drugs and includes color photographs, terms and symptoms of drug abuse, and other vital information. It will be of particular value to all the law enforcement agencies in Illinois to whom copies of this Report will be disseminated.

The Commission would also like to express its gratitude to the scores of other persons whose help made this Report possible. Although their names are too numerous to mention, we wish to thank them for whatever part they played in bringing this important work to completion.

THE ILLINOIS LEGISLATIVE
INVESTIGATING COMMISSION

FOREWORD

If this were the late 1930's, it would be comparatively simple to discuss the negative aspects of drug abuse. In those days it was taken for granted that there could be no valid controversy concerning the problem. Drugs such as heroin, cocaine and marihuana were lumped together as more or less equal in terms of inherent evil and deleterious effects on health. Those who took such drugs were regarded as the lowest species of mankind.

The communications media not only seemed to agree with this opinion, they found it excellent copy to denigrate all drug users as a relatively homogeneous class. Because of the socio-economic status of most abusers during that period of time, little, if any counter-argument was offered. The public found it easy both to ignore and to ostracize drug users. These views were mirrored in Congress and in most state legislatures. Very little concern was shown for drug victims. Instead they were classed as criminals and punished with extraordinarily severe sentences.

Until the early 1960's, drug use remained subterranean. Most of the abuse occurred in America's non-white ghettoes or among various show business groups and artistic types. Then, a new era began. Overnight, drug abuse began to spread wildly. Quickly, the use of pot and pills became fashionable among a limited but influential group of sophisticates. Soon a much different socio-economic youth group became involved. Eventually, even the most dangerous substances became drugs of abuse at virtually all levels of society. A problem of crisis proportions had arrived.

Suddenly, laws that heretofore had been reasonably effectual became difficult to enforce. Many authorities from all involved disciplines denounced the old laws as harsh and misdirected. There was an outcry for accurate information about drugs and effective treatment for victims. Most of all there was a clear need for a thorough analysis of the vast panoply of urgent needs which together formed a massive complex of issues known as "the drug problem."

This was the enigma which faced the Illinois Legislative Investigating Commission when it began its intensive study of drug abuse more than a year ago. During this period of study it has been a pleasure and an honor for me to advise the Commission in the preparation of its innovative drug legislation and this exhaustive Report. As a native Illinoisian I am proud of the peerless efforts of my home state in confronting the drug menace.

I recommend this volume to the citizen who seeks to expand his knowledge of drugs. The reader will find herein a concise presentation of the many topics and questions one must consider in order to acquire a full understanding of the drug abuse problem. The subject of drugs has been fraught with much bias and opinion. It is refreshing to come upon a publication evincing the degree of insight and understanding one finds in this work.

EDWARD R. BLOOMQUIST, M.D.*

* An Associate Clinical Professor of Anesthesiology at the University of Southern California School of Medicine, Dr. Bloomquist is an Internationally renowned authority on problems related to the abuse of dangerous drugs. He has served on committees of federal, state, and local governments. Currently, he is chairman of the California Interagency Council of Drug Abuse, and vice-chairman of the Committee on Dangerous Drugs of the California Medical Association. He has been an adviser to the Illinois Legislative Investigating Commission on matters of drug abuse for more than a year in addition to testifying on behalf of the Commission's drug bills before the Illinois House Judiciary Committee.

His article from *California Medicine* on the social effects of marihuana has been reprinted nearly a million times. In 1968, Macmillan published his book, *Marijuana*. Since then it has been recognized as a leading treatise in the drug field. A second edition, *Marijuana, The Second Trip*, was published earlier this year.

Primarily a clinician in the field of anesthesiology in which he is a certified specialist, Dr. Bloomquist teaches at the University of Southern California and at California State College in Los Angeles. He was a native of Moline, Illinois for 20 years until he moved to California.

RICHARD B. OGILVIE
GOVERNOR OF ILLINOIS
TO THE
77th GENERAL ASSEMBLY

SPECIAL MESSAGE ON DRUG ABUSE

THURSDAY, APRIL 15, 1971

To the Honorable, the President of the Senate, the Speaker of the House, and the Members of the 77th Illinois General Assembly:

Major progress against drug abuse will be difficult to achieve.

It is not beyond our capacity. But it surely will not be easy.

Past failures alone demonstrate this. Although sincere men struggled with drug abuse long before the children of affluence dropped out and brought the "drug problem" close to most of us, their efforts met only with minimal success.

Alcoholism has been a recognized problem for centuries. Alcohol still is our most widely abused drug, if not the most dangerous.

To find our failures we do not have to point to marijuana, the youth drug culture, drug-dependent Vietnam veterans, or heroin epidemics. But we ought to be troubled indeed when we concern ourselves with these latest outbreaks of drug disease.

The risk of terrible drug epidemics is very real. In February, the District of Columbia Narcotics Treatment Administration estimated that the number of heroin addicts in the nation's capital had risen from 1,162 to 16,800 in eighteen months. In a three-square-mile section of the black ghetto, it estimated that from one-fourth to one-third of the young men between ages 15 and 24 are heroin addicts.

In such neighborhods heroin rules more absolutely than any tyrant. It turns human beings into thieves and prostitutes preying on their own people. It hooks children, cheats them with the promise of instant gratification and escape, and rewards them with destruction. The result is human wreckage and whole cities gripped by fear of the crimes perpetrated by the addicts' compulsion to obtain money to buy drugs.

It can happen here. Epidemics of such magnitude have not spread in Illinois, but the risks are ever-present.

It is not an exaggeration to say that we face the danger of losing much of a whole generation — through heroin, through mind-warping hallucinogens, and through the alienation of a "soft" drug culture.

There is so much that we do not know about the drug problem, its causes, and its cures. Our children know more about drugs than we do — they have more knowledge of the illicit drugs, and they watch more alertly the drug advertising that surrounds us with easy cures for everything.

Much of our uncertainty comes from the realization that drug abuse is deeply rooted in anxieties which derive from all the things that are wrong with our society — too-rapid change, the bigness and impersonality of our institutions, deterioration of the family, the decline of religion, shifting values, hypocrisy, disregard for justice. The junkies and drug freaks are witnesses to our civilization. In the end, we may do more about drug abuse by addressing the challenges of social justice than through specific drug abuse efforts.

Yet, we cannot afford to leave the drug problem to more general attempts at social reform, for drug abuse has been greatly intensified by our technological civilization and requires a specialized response. Drug abuse today is a direct assault by our technology.

Technological advances have given us far more varied, more concentrated, and more dangerous drugs. We are experiencing a bewildering deluge of chemical substances. Our chemical technology is out of control. We do not have the values or the social controls to cope with the decisions which confront us.

We must create such controls, and develop the will and judgment to make them work — not simply by imposing them, but by making others understand and support our public policies toward drugs. This will not be easy.

I do not mean to suggest that the situation is utterly bleak. We have made progress in Illinois, and we have established the framework and the mood to make more progress. Let me mention some elements holding general promise.

This assembly and this administration have not indulged in simplistic punitive reactions to drug abuse. Two years ago, you enacted and I signed a law reducing the penalty for possession of a small amount of marijuana to a misdemeanor in the case of the first offense — thereby assuring that the penalty was not more harmful than the crime in this most common drug violation.

In expanding our methadone program, which is respected throughout the world, we have made a reality of treating narcotic addicts not merely as criminals but as human beings with a disease requiring treatment and rehabilitation. Our prisons have established a meaningful program of drug rehabilitation. The Illinois Law Enforcement Commission helped launch Project Straight Dope, a national model of effective drug abuse advertising, and supports other innovative drug abuse efforts.

The state's enforcement efforts through the Illinois Bureau of Investigation have been aimed at the pushers, not at drug users who could be exploited as easy marks for arrest and conviction. Out of 458 drug investigations in 1970, there were 514 arrests and almost all were drug sellers or would-be sellers. Ten major illicit drug distribution operations were broken, including rings involving Bloomington, Champaign-Urbana, Chicago, Des Plaines, Galesburg, Kankakee, Peoria, Rock Island and Springfield.

This is a beginning. Today I am asking your help to build on the record we have made to date.

Let me emphasize that I do not claim to offer assured solutions to the drug controversy which confronts us. But I can point the way to the reforms that commend themselves to my administration, and press others to face the issues that are there.

And in this endeavor I submit that we elected leaders, as well as those we would help, might heed the lesson we all should have learned in reaction to the drug advertisers: There is no instant remedy. There are no instant cures. There will be no instant success.

But there can be real progress.

Recognizing these troubling realties, it is with a deep sense of concern that I present the administration's drug abuse program for your consideration.

A Uniform Drug Law

The central vehicle for our legislative program is the proposed Uniform Controlled Dangerous Substances Act which has been developed by the National Conference of Commissioners on Uniform State Laws in cooperation with the U.S. Department of Justice. This bill seeks to revise, recodify and modernize the laws affecting narcotics and dangerous drugs, making them consistent among the states and with federal law. The proposed uniform bill has been conformed, where possible, with the major federal drug legislation enacted in October, 1970.

Building on the proposed uniform bill, we have compiled a comprehensive revision of the Illinois laws affecting drug abuse. The matters covered include regulatory classification and control of drugs, redefinition of the drug crimes, reform of the penalty structure, clarification of enforcement procedures, improved authority for research and treatment, allocation of responsibilities among state agencies, and refinement of the legal terms governing drug use and abuse.

Uniform state provisions which conform to federal law are particularly useful in those matters requiring interstate or federal-state cooperation. The control of drugs to prevent their diversion into illegal channels virtually demands such cooperation. Distribution is interstate, regulations should be consistent, the activities of the regulators should mesh, controls must be thorough, and regulation is more efficient and effective if the regulatory laws and policies are

uniform. Our bill accomplishes this as fully as possible.

The uniform bill will also be more flexible in controlling drugs. It proposes five classes or "schedules" differentiating the various chemical substances dangerous to humans according to degree of danger, medical usefulness, potential for abuse, and other relevant criteria. As experience develops, substances may be reclassified or dropped from the schedules if such action is advisable. New substances can be added to the schedules as technological advances bring forward new drugs.

We do not espouse uniformity just for the sake of sameness. There are matters which do not require uniformity and on these the states should go their own ways. For example, we have not included the so-called "no-knock" provision contained in the federal bill and suggested in the uniform bill, because we do not believe it will be necessary in Illinois.

We have also departed from the uniform bill in the penalty structure we propose. We believe that, on the difficult question of the most effective drug penalties, the various states may have different problems. The states are especially suited to try different ways to find the best approach to problems such as marijuana.

Reforming the Penalty Structure

I am proposing to you a new penalty structure for drug crimes in Illinois. I believe it is a better system of penalties.

It is tougher, more realistic, and more humane.

1. It is *tougher.*

It is tougher on those who deserve it — the criminals who traffic in drugs, especially with young people.

—The big traffickers, those who deal illegally in very large quantities of the most commonly peddled illegal drugs, are subject to stiff mandatory minimum penalties: 10 years for distribution and three years for possession of a large quantity.

—It is tougher on those who distribute drugs to youths under 18 and more than two years their junior — authorizing double sentences for such corrupting conduct.

—It is tougher on the leaders and financiers of the organized criminal drug traffic in the very dangerous drugs — requiring forfeiture to the Common School Fund of all assets used to sustain their illicit conspiracies, as well as sentences of 10 years to life.

2. It is more *realistic.*

It classifies drugs more realistically for penalty purposes, treating distribution violations differently from possession, separating distribution of marijuana and hallucinogens from distribution of addictive narcotics, and penalizing distribution of dangerous amphetamines and barbiturates as felonies rather than misdemeanors. Possession of large amounts of common illicit drugs — quantities large enough for major trafficking and not just individual use — is treated as a serious crime because of the clear threat of distribution to others in our society.

3. It is more *humane.*

Young first offenders with marijuana — youths 18 or under who are found in possession of two to five grams or less — may be given conditional probation without entering a judgment of conviction. If they complete their probation successfully, they are discharged without a conviction which would appear for life on their record. The maximum penalty for non-profit marijuana violations involving two to five grams or less is reduced from one year to six months, if it is the first offense.

For simple possession of all drugs, discretion is given to prosecute cases either as misdemeanors or as felonies, permitting flexibility in punishment to allow consideration of the danger of the drug, the circumstances of the offense, the nature of the offender, and other factors appropriate in possession cases.

New Measures Against the Illicit Traffic

In addition to the general strengthening of control over the illicit drug traffic which we believe will come with the uniform law, we are proposing several special measures aimed at the organized drug traffic.

One would make calculated criminal drug conspiracies a special crime with heavy penalties — 10 years to life if the offender has a prior conviction for a serious drug felony. This crime would apply to those who organize, direct, finance or obtain substantial profit from a conspiracy with two or more other persons which includes a felony involving the most dangerous drugs. It is aimed directly at the directors and financiers of major drug peddling.

A second proposal aimed at the substantial pusher is the creation of special crimes with stiff sentences for violations involving large

quantities of the illicit drugs seen most commonly on the street. An important aspect of this approach is that it extends to possession of these large quantities — for example, 30 grams of heroin, the equivalent of about 100 "nickel" bags for retail peddling to addicts. Frequently it is difficult to prove attempted sale by these large pushers, but possession of such quantities alone will sustain conviction of a dangerous criminal and require a heavy sentence.

Another improvement in our enforcement machinery includes administrative inspection warrants to strengthen inspection of commercial drug manufacturers and distributors to control diversion from legal distribution channels into the illegal market. We also propose broadened forfeiture provisions.

Treatment of Addiction

The most vicious drug problem in Illinois is addiction to heroin.

Beginning in 1968, the Department of Mental Health, with the invaluable collaboration of the University of Chicago and the advice of the Narcotic Advisory Council, began to operate its pilot program to determine which of a number of proposed approaches to the treatment of heroin addiction are best suited to the needs of the state of Illinois. The approach was to evaluate a number of different treatment techniques in terms of concrete results, such as the decrease in illicit drug use, productive activity, decreased anti-social activity, and overall cost.

At the start of 1969, there were a few more than 100 patients in treatment, all as outpatients. In July, 1969, there were about 300 patients in treatment, 30 per cent of them in full-time residential settings. By July, 1970, there were more than 900 patients in treatment.

Now the Illinois Drug Abuse Program treats more than 1600 patients in 21 facilities, seven of which have residential capacities and 10 of which are operated by private organizations who have contracted with the Department of Mental Health. While in treatment, the patient can take advantage of rehabilitative programs that are being designed to suit his individual treatment needs.

This use of multiple approaches within one coordinated administrative structure — a system pioneered by Illinois — not only benefits the patient, but also reduces the inefficiency and destructive rivalry which often characterizes the operation of single-method treatment programs operated by administratively autonomous agencies.

Mindful of the extent of the drug problem and faced with a waiting list, the state plans to increase its supported treatment facilities to 27 and the number of patients to 3,000 as fast as this can safely be done. The goal is to accomplish this by July, 1972, with the funding requested in the proposed 1972 budget.

The success of the Illinois Drug Abuse Program has been demonstrated in several ways. Among treated patients, illegal activity — a way of life for the narcotic addict — has been decreased 71 per cent, as indicated by the best data available to us. Employment has correspondingly increased 73 per cent. Most patients are now able to control their drug intake to such an extent that in any given week, 78 per cent of them have not used any illicit drugs. These figures are especially encouraging since they are based only upon outpatients.

Although the program was primarily concerned with the treatment of heroin addicts over its first two years, it is now becoming increasingly involved in providing services for young people abusing other types of psychoactive drugs. Five state-supported facilities are currently providing help for the so-called "young poly-drug abusers" who have voluntarily sought treatment. The objective of these programs is to expose young people to possible options to their drug using behavior, without purporting to impose upon them a style of living that they may feel is alien.

The fundamental goal of this administration is the development of sufficient resources so that treatment is immediately available to any drug user residing within the state. Under such circumstances, there will be little basis for the claim that criminal activity was necessary to avoid withdrawal sickness, since treatment will be an alternative to the purchase of illicit drugs. It is my conviction that it is not only better but cheaper for society to treat all addicts seeking help than to allow them to fend for themselves in the underground culture in which they now exist.

A recent analysis of 81 addicts by the Methadone Maintenance Clinic at St. Luke's Hospital Center in New York City reveals some sobering statistics which bear on this issue. In the year before their entry into the methadone clinic, according to Dr. Paul Cushman, Jr.:

> Interviews show that the 81 used approximately $900,000 worth of heroin, or nearly

$11,000 each. Over half the heroin was obtained by selling the drug to others. In most instances, the patients sold freshly purchased drugs at least once daily to regular customers, whose cash payments would permit the purchase of more heroin. The seller would normally inject himself with heroin not sold.

The 81 addicts interviewed obtained $258,000 worth of heroin through the sale of stolen property. Since the fences who would take the property usually remitted only a fraction of the fair market value of the property, the actual loss to society was much greater than $258,000. Accordingly, an attempt was made to determine the fair market value of the property actually stolen. It appears that in the recent 12-month period the 81 addicts stole goods worth about $720,000 at the market place. The interviews also showed that additional sums were stolen for living expenses.

There is no way of calculating the human suffering caused — to themselves and to others — by these addicts.

Our goal is to minimize this devastation by giving every addict a chance to get into the Illinois program, instead of being victimized by the criminal traffickers on the streets. We are seeking to achieve this goal in 1972.

"Once an addict, always an addict" need no longer be the bleak truth it once was.

Alcoholism

Alcoholism is a problem of large dimensions. We have estimated that 20 per cent of the adult admissions to state mental health facilities have a primary problem of alcoholism, and the figure is not getting smaller. In an effort to reverse this disturbing trend, we are making a strong new commitment in this area.

For our programs dealing with alcoholism, I am recommending the allocation of $6.8 million next year. This is nearly 50 per cent more than the level of the current year. Included in that figure is a substantial increase in the level of grants to community-operated agencies, which are engaged in education, referral, counseling and, in some instances, the operation of halfway houses in conjunction with local mental health clinics for outpatient treatment.

The primary emphasis of our state-run alcoholism activities will be on a shortened period of hospitalization and intensive treatment geared to complete rehabilitation. We are re-evaluating the costly program of purchase care of emergency hospitalization for this purpose, with an eye toward more fully utilizing the alcoholism units already in operation at our mental hospitals and zone centers.

Research

No individual state can single-handedly take a primary role in drug research generally. That role must be left to the federal government and our great research institutions.

But the state of Illinois can continue its leading position as a demonstration and proving ground for applied research. The Illinois Drug Abuse Program does not view itself as merely a treatment agency, but rather as a total system that also can effectively provide the community with the educational and research information it needs to cope with the problems of drug abuse.

Our methadone program pioneered in showing the effectiveness of new techniques for combatting heroin addiction, and we will continue to stress innovation. For example, a new drug, acetylmethadol, is being tested as a possible replacement and improvement upon methadone. There are indications that it may give longer relief, increase the number of patients handled, and minimize the risks of diversion and overdoses of methadone. If early indications are confirmed after more extensive research, this substance will further facilitate rehabilitation without increasing risks to the community.

The state can also improve the climate for research on drug abuse. The legislation we propose would do this by providing that the confidentiality of the identity of research subjects, under authorized research projects, could be preserved inviolate.

We also propose legislation authorizing urine tests for persons arrested, to permit factual research into the relationship between crime and drug abuse, and authorizing the drug abuse program to obtain arrest records of its patients to permit thorough analysis of the medical and social successes and failures of our treatment efforts.

Marijuana

Although I have touched previously upon marijuana, I would like to discuss that subject directly, because of the special concerns it raises at this time.

In my judgment a case has not been made for legalizing marijuana.

There is too much we do *not* know about its immediate as well as long-term effects. And there are beginning to be more scientific assertions of its harmful possibilities.

There are many varieties and mixtures of "marijuana." Each can be greatly affected by its content of active ingredients and by additives and contaminants. Some individuals appear to have unusual reactions, and sometimes these may be harmful. The intensity and the duration of use appear to have an important impact, and may produce significant psychological changes. The long-term physical and mental effects of marijuana are little known, but certainly in light of what we do know, they are cause for concern and great caution.

There is room for legitimate controversy over the meaning of some of the research that has been done. Yet based on what we know today, it appears that marijuana can be dangerous to personal and public health. The demand for drug-freedom should not take precedence over the reality of possible harm.

It also appears clearly that we were guilty of overkill in the way we punished and criminalized marijuana users in the past. We must stop driving young men and women toward the dangerous criminals who thrive on the addictive drug culture. I think it is important that we work thoughtfully to straighten out that mistake.

It is important for the users — our young people with their futures ahead of them. But it is equally important for our society and our institutions of government.

The authority of our laws and the institutions that stand behind them depend upon their being responsible and equitable. What is at issue is the credibility of government, the legitimacy of the authority that holds our society together. In this perspective, fair and workable marijuana laws may be more significant for the majority who have never thought of trying the drug than for those who do experiment with its use.

It is for these reasons that I have recommended that the distribution of marijuana be punished under a different penalty structure than narcotic drugs, and that conditional probation be authorized to avoid a criminal record for youths involved with small amounts of marijuana. For these reasons I am recommending that the maximum penalty for a first conviction involving small amounts of marijuana be reduced from one year to six months.

* * *

There are many proposals concerning drug abuse pending before this assembly. These deserve the most careful attention from all of us, for in the light of experience only the foolhardy will claim to have the *only* solutions for drug abuse.

The administration's recommendations are submitted as solid, common-sense proposals — not the panacea, but the most complete, sensible and effective reforms we can offer.

I ask your cooperation in reviewing them, and I pledge you mine.

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The Illinois Legislative Investigating Commission members attend the signing of the Illinois Controlled Substances Act and the Cannabis Control Act on August 16, 1971. Left to right are: Sen. Everett E. Laughlin, Chief Counsel Roger C. Nauert, Executive Director Charles Siragusa, Co-Chairman Henry J. Hyde, Gov. Richard B. Ogilvie, Co-Chairman Gerald W. Shea, Rep. James Y. Carter, Sen. Thad L. Kusibab and Sen. Daniel Dougherty.

STATE OF ILLINOIS
LEGISLATIVE INVESTIGATING COMMISSION
300 WEST WASHINGTON STREET
SUITE 717
CHICAGO, ILLINOIS 60606
AREA CODE 312-726-6765

October 1, 1971

To: Honorable Members of the General Assembly

There is no greater problem confronting Illinois today than the growing menace of drug abuse. Drugs in many forms are readily available on the streets of our cities and on our campuses. Narcotics, marihuana, amphetamines, barbiturates and hallucinogens are taking their toll among our young — loss of ambition, arrest records, physical and mental illness, and sometimes death, can and do result from what is obviously more than a teenage fad. And in our ghettos the nightmare of narcotics which began a generation ago, grows more frightening. On the national level, more than 100,000 Americans lead totally unproductive lives because of their addiction to narcotics.

Another dimension of grave concern has developed. The use of narcotics, marihuana, stimulants, depressants and mind altering substances has now spread to white suburbia.

The blight of illegal drug traffic — the lives it ruins and the lives it takes — has been a consuming interest of the Illinois Legislative Investigating Commission for the past year. This publication presents the findings and conclusions reached by this Commission during its past year of study.

The inquiry was begun by the Commission's predecessor, the Illinois Crime Investigating Commission. On July 1st of this year this former body was transformed into its successor agency, the Illinois Legislative Investigating Commission.

The former Commission began its inquiry into the drug abuse crisis on September 12, 1970 by adopting Specific Resolution No. 39. (See Appendix 1). The Resolution expressed the notice that the Commission had taken "of the recent proliferation in the traffic of narcotics and dangerous drugs in this state." It also expressed concern that "such drugs may be causing great human damage to the citizens of Illinois and may be a major factor in the rise of individual and organized crime in this state."

Acting on these premises the Commission's staff began its exhaustive examination of the drug problem. The inquiry, which lasted for more than a year, included field investigations, legal research and public hearings.

On October 8, 1970, the Commission travelled to Washington, D. C. for a briefing by the United States Bureau of Narcotics and Dangerous Drugs. A synopsis of this briefing is contained in Chapter 10 of this report.

On November 29, 1970 the Commission flew to California for a week-long series of interviews of drug authorities and inspections of drug institutions throughout the state. A summary of our findings can be found in Chapters 11 and 12.

A similar tour was undertaken in New York City by the Commission from April 7 through April 9, 1971. This trip is summarized in Chapter 13 of this Report.

Extensive tours of this variety were made of Illinois institutions throughout the study. The views elicited from staff members at facilities in Illinois and other states with massive drug problems were invaluable in drafting legislation and in preparing this Report.

A series of hearings commencing in Chicago on October 20, 1970 and concluding in Spring-

field on February 8, 1971 is detailed in Chapters 14 through 20. The hearings covered virtually all aspects of the drug problems.

The main purpose of these hearings and the tours was to elicit the views of drug authorities in Illinois and elsewhere in order to prepare thoughtful, corrective legislation. On March 14, 1971 House members of the Commission introduced House Bills 787 and 788. These bills represented a complete revision of the state's drug laws. The Commission worked diligently in cooperation with the Governor's Office in drafting these and other drug related bills. This comprehensive legislative package was signed into law by Governor Ogilvie in 1971. All of this legislation, as well as the new Federal Comprehensive Drug Abuse Prevention and Control Act, is discussed in Chapter 1.

The balance of this Report contains our findings, conclusions and recommendations regarding the drug abuse crisis in Illinois. Chapters are devoted to the drug problem generally, the drug culture which has developed among our youth, marihuana, narcotics, other dangerous drugs, law enforcement, drug education and treatment.

This Report is being submitted for the purpose of providing a broad purview of the drug problem in Illinois. It is not offered as a scientific treatise or as a definitive study. We have intentionally confined this Report to selected major issues of concern to the General Assembly and the citizens of Illinois.

We have learned much during this past year of research. Drug abuse in Illinois is escalating at an alarming rate. More than ever before there is an onus on the Legislature and the people of this state to understand the nature of the pestilence which surrounds us. It is this responsibility which has occasioned this Report.

Respectfully Submitted:

Rep. Henry J. Hyde
Co-Chairman

Rep. Gerald W. Shea
Co-Chairman

Daniel Dougherty
Senate Member

Philip J. Rock
Senate Member

George W. Lindberg
House Member

Harris W. Fawell
Senate Member

Hudson R. Sours
Senate Member

Joseph G. Sevcik
House Member

Thad L. Kusibab
Senate Member

Tobias Barry
House Member

Charles Siragusa
Executive Director

Everett E. Laughlin
Senate Member

James Y. Carter
House Member

Roger C. Nauert
Chief Counsel

Chapter 1
LEGISLATION

Introduction

In order to combat the tremendous increase in drug abuse which has occurred in recent years, there must be a combined attack by all relevant disciplines. The adoption of appropriate legislation is the essential first step.

During the Commission's investigation it became readily apparent that existing Illinois law did not address itself adequately to the nature of the peculiar problems generated by the drug crisis within recent years. Consequently, the Commission decided that its first obligation would be to draft legislation designed to check the rampaging drug situation. Fortunately, Illinois was among the first states in the country to meet the challenge with what we believe was thoughtful, innovative and responsive legislation.

The Illinois Controlled Substances Act and The Cannabis Control Act, drafted by the Commission in cooperation with concerned Illinois legislators and the Governor's office, are the primary subject of this chapter. Governor Richard B. Ogilvie signed these and companion laws on August 16, 1971, stating:

> I have acted today upon a score of bills which enact the most comprehensive program of drug law reform in the history of Illinois. It is a real landmark, and a great credit to all the responsible officials who contributed.
>
> The response was admirable. The bills I am approving today are the product of constructive leadership from both sides of the aisle in both houses of the General Assembly. Valuable contributions were made by the Illinois Crime Investigating Commission, the Illinois Narcotic Advisory Council, and various agencies of this administration.
>
> The result is legislation creating the controls needed to meet the challenge of drug abuse in a changing society. We are only too aware of the frightening rise of drug abuse reaching from the streets into our schools and into our homes. This legislation gives us the capability to confront the constant

changes which are occurring. It establishes a more realistic penalty structure, provides regulatory flexibility to cope with new chemical inventions and variations of dangerous drugs, and links the state control structure closely to the federal system.

Six newspapers editorially praised the passage of these laws: the *Chicago Tribune* of August 19, 1971, the *Chicago Sun Times* of August 18, the *St. Louis Globe-Democrat* of August 18, the *Chicago Daily News* of August 24 and the *Chicago Today* of August 24. The *Chicago Tribune* editorial is quoted below:

> Governor Ogilvie has signed into law sweeping drug reform legislation which includes a dramatic reduction of penalties for sale and possession of marihuana. Much as we deplore the prevalent use of marihuana, we welcome this realistic step in the hope it will result in more effective enforcement of drug control and an eventual solution to the drug problem.
>
> The old law, as its critics pointed out, was almost medieval in its harshness and became utterly unenforceable as the use of marihuana spread. It called for jail sentences of from 10 years to life for the sale of a single marihuana cigarette and up to 10 years for the mere possession of more than 10.
>
> To avoid dealing so harshly with the growing number of youthful offenders, the courts began dismissing charges in wholesale lots, making the law something of a joke. We were often treated to the sight of policemen standing idly by while thousands of young rock festival patrons smoked their pot in public view.
>
> The new laws, we hope, will change all that. Drafted by the Illinois Crime Investigating Commission [Illinois Legislative Investigation Commission] in concert with the Ogilvie administration, they declassify marihuana as a hard narcotic and then set it up in a dangerous drug category of its own.
>
> Penalties have been reduced to the point where no judge can feel any compunction about meting out punishment. A person convicted of possession of a marihuana cigaret now faces a maximum of only 90 days in jail, and under some circumstances, can be released on probation. Sellers and possessors of larger amounts face stiff penalties, but none so stiff as life imprisonment.
>
> The law increases the penalty for the sale of small amounts of LSD and other such drugs from a maximum of one year in jail to a maximum of 20. Penalties for possession of heroin and other hard narcotics were also increased.
>
> In a laudable innovation, the new laws also include a provision aimed at the crime syndicate. Any two or more persons convicted of conspiring to profit by more than $500 thru the sale of narcotics, marihuana or any dangerous drugs face stiff jail sentences and fines of up to $200,000. The syndicate may consider its minions expendable, but it doesn't feel that way about its money.
>
> Gov. Ogilvie and the legislative sponsors of the bills emphasize that in liberalizing the marihuana laws they are not advocating the legalization of marihuana.
>
> Liberal defenders and users of marihuana maintain that it is no more harmful than tobacco or alcohol, but evidence to the contrary is mounting. Medical experts from California testifying before the crime commission told of one advanced mathematics student who was unable to work simple equations after prolonged marihuana use. Others warned of a pronounced apathy caused by the substance, harmful not only to the user but to society in general.
>
> While only a few marihuana users escalate to harder drugs, evidence shows that the overwhelming majority of hard narcotics users started with marihuana.
>
> Indeed, marihuana use remains a significant part of the whole drug problem. With the new laws, Gov. Ogilvie and the legislature have shown they are willing to deal with it effectively and rationally.

Also included in this chapter are brief descriptions of 13 additional bills that were signed into law by Governor Ogilvie on August 16, 1971. One of them, the Dangerous Drugs Advisory Council Act, comprises the final third part of the Commission's legislative drug control package. The other bills were drafted by representatives of the Governor's office, represent a series of amendments to 12 existing laws, and made appropriate changes in terminology to conform with the Illinois Controlled Substances Act and the Cannabis Control Act.

The final portion of this chapter is devoted to the new Federal Act which made sweeping changes at the national level and which contained many concepts reflected in the commission's drug legislation package.

The Illinois Controlled Substances Act (Public Act 77-757)

1. *Introduction.* With major changes in federal narcotic and dangerous drug laws came the need for the states to revise similarly their own respective drug control statutes. Previous-

ly, most states had adopted the "Uniform Narcotic Drug Act" because it was designed to correspond to the previous federal law. After 1970, however, the enactment of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 made this Federal basis meaningless. In August of 1970 the National Conference of Commissioners on Uniform State Laws responded by announcing its draft of the "Uniform Controlled Substances Act". This Act was intended to become a model for all state drug laws to replace the Uniform Narcotic Drug Act and once again achieve nation-wide uniformity and provide an "interlocking trellis of federal and state law to enable government at all levels to control more effectively the drug abuse problem."

In Illinois, there had long been a movement to revise the state's system of drug control. With the drug abuse problem rising to epidemic proportions it was evident that the prevailing laws were ineffectual in terms of deterrence, prevention, or rehabilitation. The advent of the new federal law and the release of the corresponding Model Act created the opportune time to effect these needed changes.

Variations of the Model Act began to be introduced by a number of interested legislators, each reflecting various degrees of research and differing philosophies. Of course, as is the problem with most "model" laws, many of the Model Act's provisions were not compatible with several Illinois Statutes, the Criminal Code in particular. Therefore, a number of substantial changes had to be made in the Model Act to tailor the new law to the particular needs of Illinois. In addition, the new law would have to reflect the most current information available on the problem of drug abuse as it exists in Illinois. The result was the introduction of the "Illinois Controlled Substances Act" by members of the Illinois Crime Investigating Commission on March 4, 1971.

The Commission's study of the drug problem in Illinois uncovered many areas in which legislative reappraisal was needed. Eminent jurists and other officials in the criminal justice system asserted that the prior law's harsh minimum mandatory sentences for drug offenses were causing reluctance to convict on the parts of judges, juries, and prosecutors. This reluctance had led in turn to judicially undesirable "plea bargaining." Wider judicial discretion was advocated in matters of sentencing so that they might better tailor the punishment to fit the characteristics of each individual offense.

Treatment and rehabilitation authorities complained that they had little opportunity to check the effectiveness of their work because there was a lack of communication between themselves and law enforcement agencies. They asked for cooperation in providing relevant arrest data and a means to maintain a close check on their "patients". Correctional officers stated that there was insufficient knowledge in the area of treatment for drug offenders who were placed in their custody, and called for increased research efforts to provide them with meaningful and effective rehabilitation methods.

Finally, many legislators and interested citizens voiced their objections to the inequality and often gross unfairness which resulted from treating both drug users and drug pushers with the same heavy-handed severity. They insisted that changes be made to differentiate between the addict, who poses a medical or psychological problem, and the drug pusher, who is more often a genuinely criminal problem.

The Illinois Controlled Substances Act addresses itself to these and other considerations. Utilizing the Model Act as a basic framework, it ties in with the new federal scheme by establishing schedules of drugs, defining similar violations, creating tighter regulatory controls, establishing administrative inspection procedures, and facilitating research and rehabilitation for drug abuse.

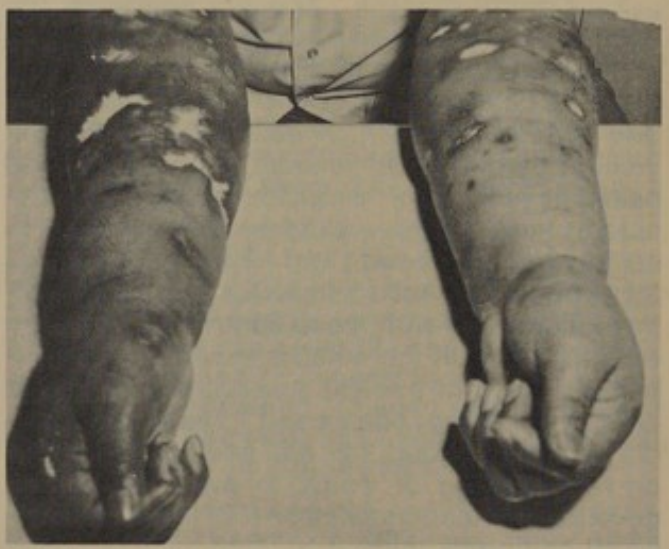
The following is a conceptual analysis of the Illinois Controlled Substances Act. The full text of the Act is contained in Appendix 2 of this report.

2. *Control System.* The Act combines under one comprehensive system the control of all drugs which have a potential for abuse except marihuana which is the subject of a second statute. The drugs embraced in the Act include narcotics, stimulants, depressants, and hallucinogens. For purposes of technical accuracy these drugs are generically referred to as "controlled substances." The specific drugs included in the Act's schedules correspond almost identically with those controlled under the federal law, with the notable exception of marihuana. Each of the five schedules has its own criteria for drug placement. Detailed procedures are provided for the addition, deletion, or rescheduling of drugs to meet future discoveries and contingencies. For maximum national uniformity there is an automatic adoption provision whereby drugs which are added, deleted, or rescheduled by the federal government are simultaneously added, deleted or re-

scheduled for purposes of Illinois law. Administrative hearings are provided for persons adversely affected by such changes under the aegis of the Director of Law Enforcement.

3. *Deletion of Marihuana Provision.* Perhaps the major difference between the Illinois and the federal schedules is that marihuana, treated as a Schedule I substance under the federal law, is omitted from the Act. Instead, acting on the consensus of the drug authorities who testified before it, the Commission made marihuana the subject of an entirely separate statute, the "Cannabis Control Act". The conclusion to separate marihuana from the other dangerous drugs was reached in light of the facts that: 1) the use of marihuana is far more widespread and socially acceptable than the abuse of other controlled drugs; 2) the inclusion of marihuana in the Act would necessitate its inclusion in Schedule I, and this in turn would require numerous exceptions to the Schedule I penalty structure; and 3) the issues of marihuana use and the abuse of other drugs are frequently completely separate topics of discussion and argument, and so separate legislation would facilitate a final resolution by clearly defining the issues.

4. *Scheduling Criteria.* The new system of treating all controlled drugs, except marihuana, on the basis of their dangerous propensities solves a troublesome and often provocative inconsistency which existed in Illinois prior to the passage of the Act. At that time, narcotic drugs were controlled under the "Uniform Narcotic Drug Act", and violations of all types were sanctioned by severe minimum mandatory penalties, which often extended to mandatory life imprisonment. On the other hand, non-narcotic drugs were controlled under the "Drug Abuse Control Act". The penalties for violations of this Act were, for the majority of cases, merely misdemeanor penalties, i.e., up to 1 year in jail and $1,500 fine. These non-narcotics included such virulent substances as LSD, "speed", and the barbiturates. This dichotomization was both unrealistic and inconsistent, as proven by scientific studies which showed that some of the more powerful non-narcotic drugs, such as LSD, are often much more deleterious to the individual than any of the narcotics. Under the new Act, chemical classifications such as "narcotic" and "non-narcotic" no longer play the determinative role. Each drug is controlled according to its relative danger to society. This danger is predicated on three criteria: 1) whether the drug has a currently accepted medical use; 2) whether it has a potential for abuse; and 3) whether it may lead to physical or psychological dependence.



Abscesses on an addict's forearms were caused by infected hypodermic needles, razor blades and safety pins.

5. *Regulatory Aspects.* The regulatory aspects of the Act are also designed to correlate with those of the federal law. Simply stated, all persons who manufacture, possess or distribute controlled drugs in Illinois must obtain a registration from the Department of Registration and Education. These registrations will be granted to applicants only if, in the judgment of the Department, it is in the public interest to do so. Conversely, registrations may be suspended or revoked if the registrant engages in certain proscribed activities which indicate that he is unfit to be trusted with the responsibilities inherent in legitimate drug commerce. This allows the state to screen and keep a check on persons engaged in the licensed drug industry. Since the state and federal registration requirements are nearly identical, there are provisions which enable a registrant to comply with the state requirements by showing that he has complied with the corresponding federal requirements. This feature eliminates costly duplications of effort and needless bookkeeping.

Inventories and records of transactions must be kept by all registrants (a requirement identical with federal law) and these must be available at all times for inspection by the Department of Law Enforcement. This provision will allow constant surveillance of the legitimate drug trade and enable law enforcement authori-

ties to detect and deter any diversion of drugs into criminal hands.

The prescription requirements of the Act borrow extensively from the prior law. All Schedule II drugs must be prescribed on official triplicate forms. All other prescriptions must be in writing and kept on record for 2 years, except in certain emergency situations.

6. *Penalty Structure.* The offenses and penalties defined and provided by the Act illustrate an area where the particular needs of Illinois required a divergence from both the Federal and the Model Acts. Under the Federal Act, the possession of any amount of any controlled drug is merely a misdemeanor, unless the possession is accompanied by an intent to sell or distribute. This latter point has traditionally been difficult for prosecutors to prove, and so in many cases the grossest violators of the law have not been penalized to the extent authorized by the law. Therefore, the new Illinois Act provides that possession of certain large amounts of the more dangerous controlled drugs will be punishable by much heavier penalties (3 years to life and a $100,000 fine) than otherwise authorized for possession offenses. In this way, the possession of relatively large amounts of drugs will constitute a conclusive presumption that the possession was with the intent to sell or distribute. The amount criteria for this class of offenses have been set at a sufficiently high level so that the presumption is more than reasonable.

Other possession offenses which are not included in the above-mentioned section are punishable by imprisonment for 0 to 8 years and a fine of not more than $15,000.

Penalties for the illegal sale or distribution of controlled drugs are also in part based on an amount criterion. In an effort to seek out the most invidious drug criminals, higher penalties are authorized for those persons who illegally sell or distribute large amounts of the most dangerous and most highly abused drugs. The penalty for this type of offender is a term of imprisonment for 10 years to life and a fine of not more than $200,000.

Penalties for all other sales offenses are based upon the schedule in which the drug is classified. These penalties range from imprisonment for 1 to 20 years and a fine of $25,000 to imprisonment from 0 to 3 years and a fine of not more than $5,000. A complete table of penalties and offenses appears:

OFFENSES AND PENALTIES

Offenses	*Penalties*
(A) Distribution	
Distribution of large amounts of certain very hazardous drugs (such as 30 grams of heroin, cocaine, morphine or LSD)	10 years - LIFE 0 - $200,000 fine
Distribution of all other *narcotic* drugs in Schedules I or II	1 - 20 years 0 - $25,000 fine
Distribution of *non-narcotic* drugs in Schedules I or II	1 - 10 years 0 - $20,000 fine
Distribution of Schedule III drugs (including most amphetamines and barbiturates)	1 - 8 years 0 - $15,000 fine
Distribution of Schedule IV drugs (such as chloral hydrate and phenobarbital)	0 - 3 years 0 - $10,000 fine
Distribution of Schedule V drugs (including medicinal mixtures which contain narcotic drugs such as codeine elixer)	0 - 3 years 0 - $5,000
(B) Possession	
Possession of large amounts of certain very hazardous drugs (such as 30 grams of heroin, cocaine, morphine or LSD)	3 years - LIFE 0 - $100,000 fine
Possession of any other amount of any controlled substance	0 - 8 years 0 - $15,000 fine
(C) Counterfeit Substances	
(Controlled substances which bear the label or trademark of a company other than that which in fact manufactured or distributed the substance)	

Distribution of a Schedule I or II counterfeit substance which is a *narcotic* drug	1 - 12 years 0 - $25,000 fine
Distribution of a Schedule I or II counterfeit substance which is not a *narcotic* drug	0 - 8 years 0 - $20,000 fine
Distribution of a Schedule III counterfeit substance	0 - 5 years 0 - $15,000 fine
Distribution of a Schedule IV counterfeit substance	0 - 3 years 0 - $10,000 fine
Distribution of a Schedule V counterfeit substance	0 - 1 year 0 - $5,000 fine
Distribution or possession of any substance represented to be a controlled substance	0 - 10 years 0 - $15,000 fine
(D) Calculated Criminal Drug Conspiracy	
(Offenses involving organized crime elements)	10 years - LIFE 0 - $200,000 fine Forfeitures
(E) Commercial Offenses	
(Offenses involving failure to comply with the requirements of the Act)	0 - 3 years 0 - $10,000 fine
(F) Fraud Offenses	
(Offenses relating to the manufacture and distribution of controlled substances)	0 - 3 years 0 - $30,000 fine
(G) Distribution to Juveniles	
(Distribution by a person over 18 to a person under 18, and three years his junior.)	Twice the penalty otherwise authorized
(H) Second or Subsequent Offenses	Twice the penalty otherwise authorized

7. *Conditional discharge.* Any person found guilty of a possessory offense other than an offense under the large-amounts section, and for whom it is a first offense, may qualify for "conditional discharge". At the discretion of the court, that person may be released on certain terms and conditions. If, after the conditional period is over and that person has complied with the orders of the court, the charges against him may be dismissed and the record expunged of any evidence of conviction or adjudication of guilt. This provision, which is available only once for any individual, is designed to eliminate the stigma of a criminal record from those persons who have naively abused drugs but who have exhibited no other signs of criminality. With slight variations, this provision is found in both the Federal and the Model Acts.

8. *Judicial latitude.* In response to the suggestions of noted jurists, the Act provides sentencing guidelines which enunciate the policies of the legislature to aid the judge in determining a proper sentence in each case. Of course, the guidelines section is merely advisory and in no way limits the judge's discretion to order any sentence authorized by the Act.

9. *Calculated criminal drug conspiracy.* There is a special provision in the Act which is designed to penalize most heavily the most repugnant form of drug offenders, those involved in organized crime. These are the persons who profit most from preying on the weaknesses of others, while seldom themselves experiencing the horror of drug addicition. It is estimated that next to syndicated gambling, drug trafficking is the most lucrative of the mob's enterprises. The Act, therefore, establishes a "calculated criminal drug conspiracy" and provides an appropriately heavy sentence of 10 years to life imprisonment and a fine of $200,000. A person may be convicted under this provision if he commits any of the more serious trafficking offenses under the Act, in concert with two or more persons, and derives anything of value greater than $500 from the conspiracy. In addition to the penalties stated above, the offender would also forfeit to the State of Illinois all receipts obtained by him through the conspiracy and any property rights or interests in property which were used in connection with the conspiracy. This provision is patterned after Section 408 of the Federal Act, but has been significantly streamlined to facilitate prosecution.

10. *Other significant features.* The Department of Law Enforcement is given the duty to

enforce the Act. Provisions are included which allow the service and execution of administrative search warrants and applications to the courts for orders enjoining violations of the Act. The Director of Law Enforcement is given the specific mandate of cooperating with other state and federal agencies in the course of discharging his responsibility to halt the traffic and abuse of illicit drugs.

Any drugs which are manufactured, possessed or distributed in violation of the Act, and all valuables, materials, equipment, containers or vehicles which are used in violation of the Act, may be forfeited to the State of Illinois. The concept of this provision mirrors similar provisions in the Criminal Code.

The Department of Mental Health is mandated to encourage research on the controlled drugs. To this end it may conduct studies of the drugs themselves or their abuse patterns, develop methods for better implementing the Act, and contract for special research with other private or public agencies. If the Department of Mental Health uses research subjects, it may withhold their names from law enforcement agencies and may not be compelled to disclose their identity in any civil, criminal, administrative, or legislative proceeding.

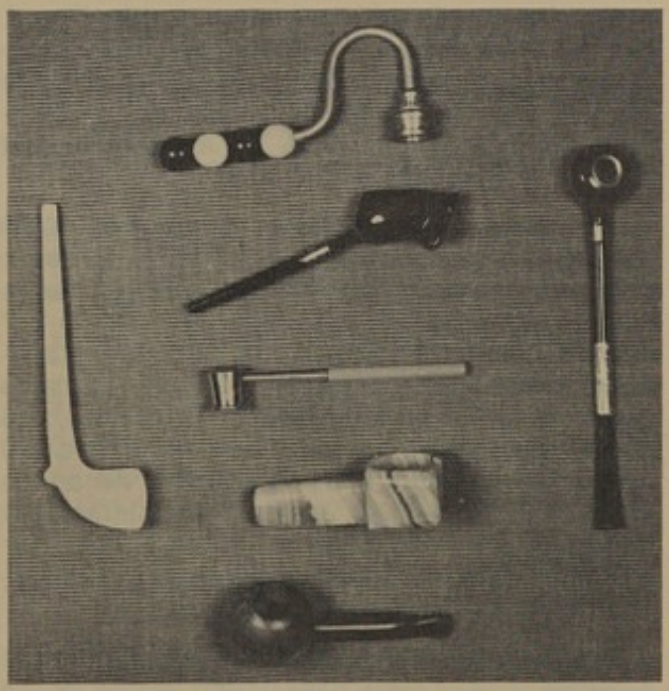
Whenever a court grants probation to any person believed to be an addict or a user of controlled drugs, it must require as a condition of probation that the person submit to periodic chemical detection tests to determine if he is abstaining from drug abuse. This provision also applies to the Parole and Pardon Board. This is another instance where the particular needs of Illinois necessitate a departure from the Model Act.

From the above discussion, it can be seen that the Illinois Controlled Substances Act has an entirely different thrust than its predecessor drug control laws. It takes what is believed to be a more enlightened approach to the drug abuse problem. Surely, there is much yet to be learned about the causes of drug abuse and the most effective ways of stopping it; but this new Act attempts to utilize all the expertise now available while remaining open and flexible enough to accommodate future discoveries.

The Cannabis Control Act (Public Act 77-758)

1. *Introduction.* The Cannabis Control Act is a companion statute to the Illinois Controlled Substances Act. The term "Cannabis" means all the pharmacologically active parts of the Cannabis Sativa plant, and includes marihuana, hashish and tetrahydrocannabinol (THC). As mentioned in the previous section, it was the consensus of the drug authorities who testified before the Illinois Crime Investigating Commission that more effective drug control could be accomplished by legislatively separating marihuana from the other drugs. As will be demonstrated herein, the Cannabis Control Act allows a more rational means of control and provides a less cumbersome vehicle for specifically detailing marihuana offenses according to meaningful weight standards.

Marihuana occupies an unusual position on the scene of the "Drug Revolution." Prior to the enactment of the Cannabis Control Act, penalties for the sale of marihuana could extend to mandatory life imprisonment. Yet the use of marihuana expanded to the point of becoming a cult among many segments of our population. Harsh mandatory penalties, which should have constituted an effective deterrent force, merely provided an issue to increase the polarization of the generations. Those who were part of the culture which accepted, even extolled, the use of marihuana consistently dis-



A wide assortment of small "hash" pipes are available to the smoker of hashish and marihuana. All resemble ordinary small tobacco pipes, usually made of brass, wood, stone or clay. Most are characterized by an unusually shallow bowl.

obeyed the law with impunity, alleging that it was unjust, that it did not reflect the opinions of the people, and that it constituted an overt act of repression. Very likely, a condition which contributed greatly to this massive disregard for the law was the well-known fact that judges, juries, and prosecutors were often reluctant to enforce the law to its fullest extent. To do so would require imposing harsh mandatory sentences. Consequently, many marihuana offenders found themselves charged with lesser offenses or freed altogether despite the sufficiency of the evidence against them.

It was not only the younger generation which was opposed to these laws. Occasionally, an offender was duly convicted according to law and given, for example a ten year term for the sale of a few grams of "pot". In many cases such convictions were met with resounding public clamor against what was believed to be gross unfairness and injustice.

2. *Penalty structure.* The Cannabis Control Act was designed to be responsive to this relatively modern social phenomenon and to reflect the latest scientific facts and findings concerning marihuana use. Like the Illinois Controlled Substances Act, it also emphasizes control at the point of large-scale distribution and drastically reduces penalties for mere users. Possession and sale of marihuana remain illegal, but the penalties for violations are based on a schedule of amounts. The amounts which were chosen for cut off points reasonably accomplish the type of selective control which best fulfills the purposes of the Act.

For possession, penalties range from 0-90 days for 2.5 grams or less, to 1-5 years for more than 500 grams. Distribution penalties range from 0-180 days for 2.5 grams or less, to 1-7 years for more than 500 grams. In street standards, 1 marihuana cigarette normally contains about ¼ gram of marihuana. Therefore, 2.5 grams is equal to roughly 10 cigarettes, and 500 grams equals about 2000 cigarettes. An ounce is equal to 28 grams. In practice, this amount structure will reasonably distinguish the user or casual seller of marihuana from the commercial, criminal trafficker in marihuana.

Many of the features of the Illinois Controlled Substances Act have been incorporated in the Cannabis Control Act. There are provisions which increase penalties for certain subsequent offenses. Sales of marihuana to persons under 18 years of age warrant double penalties. It is illegal to knowingly grow or harvest the Cannabis Sativa plant. Organized crime is singled out for severe penalties by the section which defines the calculated criminal cannabis conspiracy. Conditional discharge is available for offenders who commit minor offenses and have no previous convictions under any drug related laws of any jurisdiction. A table of offense classifications and penalties appears below:

OFFENSES AND PENALTIES

	Offenses	*Penalties*
(A)	Distribution	
	Distribution of 2.5 grams or less of cannabis	0 - 180 days
	Distribution of more than 2.5 grams but not more than 10 grams of cannabis	0 - 2 years
	Distribution of more than 10 grams but not more than 30 grams of cannabis	0 - 3 years
	Subsequent offense	0 - 4 years
	Distribution of more than 30 grams but not more than 500 grams of cannabis	1 - 4 years
	Subsequent offense	2 - 8 years
	Distribution of more than 500 grams of cannabis	1 - 7 years
	Subsequent offense	2 - 10 years
(B)	Possession	
	Possession of 2.5 grams or less of cannabis	0 - 90 days
	Possession of more than 2.5 grams but not more than 10 grams of cannabis	0 - 180 days
	Possession of more than 10 grams but not more than 30 grams of cannabis	0 - 1 year
	Subsequent offense	1 - 2 years

Possession of more than 30 grams but not more than 500 grams	1 - 3 years
Subsequent offense	2 - 6 years
Possession of more than 500 grams of cannabis	1 - 5 years
Subsequent offense	2 - 7 years
(C) Distribution to Juveniles	
(Distribution of cannabis by a person over 18 to a person under 18 and 3 years his junior)	Twice the penalty otherwise authorized
(D) Production of the Cannabis Sativa plant	0 - 1 year 0 - $1,500 fine
(E) Calculated criminal cannabis conspiracy	
(Offenses involving organized crime elements)	3 - 10 years 0 - $200,000 fine Forfeitures
Subsequent offense	5 - 20 years 0 - $200,000 fine Forfeitures

3. *Other significant features.* Research on marihuana may be conducted with the authorization of the Department of Mental Health and the approval of the Department of Law Enforcement. As with research conducted with other controlled drugs, the research facility may withhold the identity of its research subjects from all law enforcement agencies and may not be compelled to disclose their identity in any civil, criminal, administrative or legislative proceeding.

All marihuana or related substances which are produced, possessed or distributed in violation of the Act may be forfeited to the State, in addition to all materials, equipment, or vehicles which are used to violate the Act.

A final section of the Act makes the penalties for marihuana violations partially retroactive, i.e., the new penalties apply to cases being prosecuted under the previous law if they are less than those under the previous law, and if the case has not yet reached the sentencing stage or a final adjudication. The Act is reprinted as Appendix 3 of this Report.

The Dangerous Drugs Advisory Council Act. (Public Act 77-774)

The Dangerous Drugs Advisory Council Act comprises the final third part of the Commission's legislative drug control package. The Act amends certain sections of the "Drug Addiction Act," Ill. Rev. Stat. Ch. 91½, Sections 120.1 et. seq. (1969), to conform to the changes engendered by the enactment of the Illinois Controlled Substances Act and the Cannabis Control Act. It changes the name of the "Narcotics Advisory Council" to the "Dangerous Drugs Advisory Council" and adds to its powers and duties.

The Council's scope of inquiry is expanded to include all drugs listed as controlled substances under the Illinois Controlled Substances Act, and marihuana, as defined in the Cannabis Control Act. Its membership is increased to include the following persons:

1. The Director of the Department of Mental Health (Chairman);
2. The Director of the Department of Law Enforcement;
3. The Director of the Department of Public Health;
4. The Superintendent of the Illinois Bureau of Investigation;
5. The Director of the Illinois Drug Abuse Program;
6. The State's Attorney of Cook County;
7. A State's Attorney from a county other than Cook;
8. The Director of Vocational Rehabilitation;
9. The Director of Public Aid;
10. The Director of Children and Family Services;
11. A judge from the Circuit Court of Cook County;
12. The Superintendent of Police from the City of Chicago;
13. The Commissioner of the Board of Health of the City of Chicago;
14. Three Members of the House of Representatives;
15. Three Members of the Senate;
16. Eight Public Members who have relevant knowledge or experience.

Stores in Chicago have begun selling items known as "head supplies" which are intended for use in connection with drugs, principally marihuana.

The Council's primary function is to plan and coordinate the efforts of state and private organizations in the field of drug abuse prevention and control. In addition to previously established duties, the Council now has the authority to determine the feasibility of establishing a more comprehensive, state-wide drug education program for administration in all Illinois schools. This program would be designed to discourage the abuse of dangerous drugs and ideally act as a countervailing force to the peer group pressure which initiates many youngsters into the drug scene.

Another feasibility study would concern the advisability of drafting a "Uniform Drug Arrest Form" for use by all law enforcement agencies in the state. This form would include all the traditional arrest data, and add such facts as would aid the Council in making its annual report and recommendations.

Perhaps the most notable addition to the duties of the Council is its new duty to submit a detailed written annual report to the Governor and members of the General Assembly on certain specified aspects of the drug abuse problem in Illinois. This report would include information relating to drug abuse generally, arrest statistics, recidivism among drug abusers, the effectiveness of state treatment programs, the incidence of drug overdose deaths in the state, medical and scientific studies and advances relevant to the drug abuse problem, and other matters which the Council deems relevant.

It is believed that this Act, in conjunction with more enlightened drug regulation, will effectively reduce the drug abuse problem. It will unify what was previously a fragmented approach to drug rehabilitation and prevention and channel limited resources to where they will have the most impact. The Act is reported as Appendix 4 of this Report.

Other Revisions in Illinois Law

The enactment of the foregoing new major drug control laws in Illinois created the need to conform the other sections of the Illinois Revised Statutes. This was accomplished through a series of amendments which, in substance, did no more than make appropriate changes in terminology. These amendatory acts were as follows:

1. Public Act 77-763, relating to the "Out-Patient Clinics in Chicago Act";
2. Public Act 77-764, relating to the "State Reformatory for Women Act";
3. Public Act 77-765, relating to the Illinois Food, Drug and Cosmetic Act. This amendment also deleted certain language relating to prescription requirements, which are now detailed in the "Illinois Controlled Substances Act";
4. Public Act 77-766, relating to the Nuisances Act;
5. Public Act 77-767, relating to the School Code;
6. Public Act 77-768, relating to the sections of the Criminal Code which set forth non-probational offenses;
7. Public Act 77-769, relating to the Civil Administrative Code;
8. Public Act 77-770, relating to "An Act in relation to control and regulation of narcotic and dangerous drugs and to make an appropriation therefor";
9. Public Act 77-771, relating to the "Hypodermic Syringes and Needles Act";
10. Public Act 77-772, relating to sections of the Criminal Code;
11. Public Act 77-773, relating to the Personnel Code; and
12. Public Act 77-775, relating to the "Community Mental Health Act."

These amendatory Acts complete the revision of the drug control laws of Illinois. The full texts of these Acts may be found in Appendices 5 through 16 of this report.

The Comprehensive Drug Abuse Prevention and Control Act of 1970

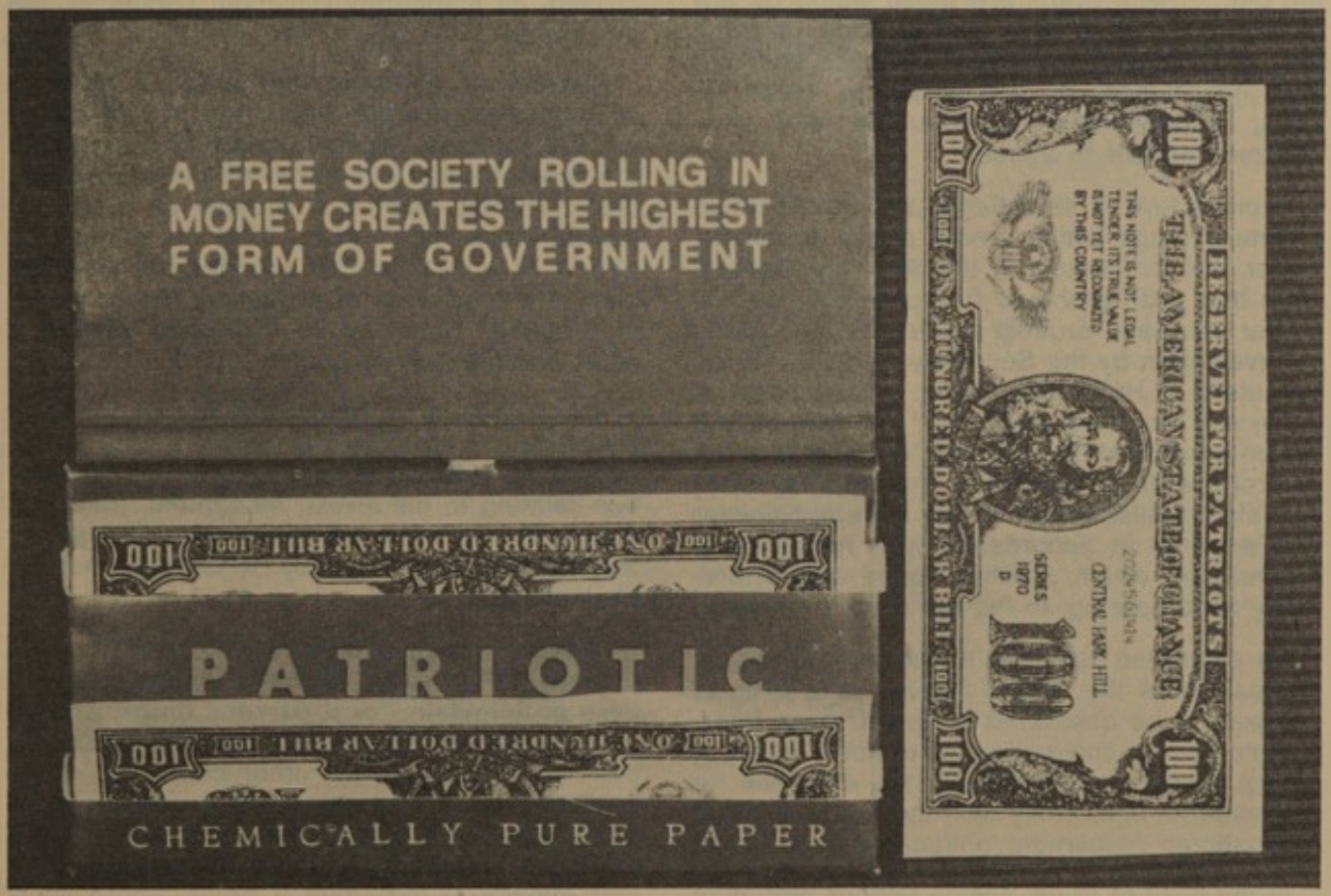
1. *Introduction.* The tremendous increase in drug abuse during the past few years has caused legislators, judges and other government officials to re-evaluate our nation's drug laws both at the federal and state levels. Numerous inadequacies in terms of scope, and emphasis were immediately apparent.

As mentioned earlier in this chapter the Commission's research into the drug problem and drafting of legislation closely paralleled that of the Federal government. The new Federal drug law, which became effective on May 1, 1971, is a landmark in enlightened criminal legislation.

Under the sponsorship of the United States Department of Justice and the Federal Bureau of Narcotics and Dangerous Drugs new legislation was drafted to replace virtually the entire body of federal law relating to drug abuse.

On October 14, 1970 both Houses of the Congress approved the Comprehensive Drug Abuse Prevention and Control Act of 1970. President Nixon signed the bill on October 27, 1970. The Act consists of four titles: Title I establishes rehabilitation programs relating to drug abuse; Title II provides authority for the Justice Department with respect to the law enforcement aspects of control of drug abuse; Title III covers provisions relating to importation and exportation of drugs subject to abuse; and Title IV deals with advisory councils. The following analysis is based on a synopsis produced by the Federal Bureau of Narcotics and Dangerous Drugs.

2. *Rehabilitation.* The bill provides authority for the Department of Health, Education, and Welfare to increase its efforts in the rehabilitation, treatment, and prevention of drug abuse, through community mental health centers and through public health service hospitals and facilities. Over a 3-year period, $75 million in



Inside the packet of papers is imprinted: "A free society rolling in money creates the highest form of government." A sardonic reference to American capitalism, the phrase "rolling in money" is a double entendre referring at once to both wealth and rolling marihuana cigarettes.

increased authorizations are provided for community mental health center facilities to deal with narcotic addicts and drug dependent persons, $29 million is authorized for drug abuse education activities, and $60 million is authorized for special facilities in areas having percentages of narcotic addicts and drug dependent persons.

Increased research and training activities are authorized through the National Institute of Mental Health out of appropriations otherwise authorized for that institute. Section 4 of the bill would encourage treatment of narcotic addicts by individual physicians.

3. *Control and Enforcement.* The bill provides for control by the Justice Department of problems related to drug abuse through registration of manufacturers, wholesalers, retailers, and all others in the legitimate distribution chain, and makes transactions outside the legitimate distribution chain illegal.

The drugs with respect to which these controls are enforced initially are those listed in the bill. These drugs are those which by law or regulation have been placed under existing law. This includes all hard narcotics and opiates, marihuana, all hallucinogens (such as LSD), amphetamines, barbiturates, and tranquilizers subject to abuse.

A procedure is established for classification of future drugs which create abuse problems. Under this procedure, if the Attorney General feels that a drug should be controlled, he will gather data, and request a scientific and medical evaluation by the Secretary of HEW. If the Secretary of HEW determines, on the basis of these and any other data, that the drug should not be controlled, the Attorney General may not control the drug; otherwise, the Attorney General may publish notice in the Federal Register and proceed in accordance with rule making procedures, which provide notice and opportunity for a hearing, to list the drug for control.

An exception is made in the case of treaty obligations of the United States. If a drug is required to be controlled pursuant to an international treaty, convention, or protocol in effect on the enactment of the bill, the drug will be controlled in conformity with the treaty or other international agreement obligations.

In the case of drugs posing serious addiction or abuse problems (those listed in Schedules I and II) tighter controls are provided. These controls include the establishment of quotas for imports and for domestic manufacture. Transfers of these drugs may only be made through the use of officially prescribed order forms, with a copy furnished the Attorney General.

All persons in the distribution chain are required to be registered, and, with certain exceptions, must keep records with respect to all transfers of controlled drugs. Practicing physicians are required to keep records of Schedule I substances; keep records of narcotic drugs in other schedules which they dispense (as distinguished from prescribing or administering) to patients and if they charge for other controlled-drugs regularly, keep records of these transactions. Researchers are not required to keep records with respect to controlled substances used by them at registered establishments that keep records.

4. *Criminal Penalties.* The bill revises the entire structure of criminal penalties involving controlled drugs by providing a consistent method of treatment of all persons accused of violations. With one exception involving continuing criminal enterprises, hereafter discussed, all mandatory minimum sentences are eliminated.

Possession of controlled drugs is made a misdemeanor, except where the possession is for the purpose of distribution to others. In the case of a first offense of simple possession, the court may place the offender on probation for not more than 1 year. If at the end of the period of probation the offender has not violated the conditions of probation, the proceedings against him may be dismissed without a court adjudication of guilt.

If the offender is below the age of 21 when the offense occurs, he may obtain a court order expunging from all official records all recordation relating to his arrest, indictment, trial, and finding of guilt. The procedure described above for first offenders may only be utilized once by an individual.

Manufacture or distribution of illicit drugs is punishable by up to 15 years in prison in the case of Schedule I or II narcotic drugs, and by up to 5 years in the case of non-narcotic Schedule I or II drugs or any other controlled drugs in Schedule III. Illegal sales or manufacture of Schedule IV drugs (generally minor tranquilizers) would carry a 3-year sentence. A first offense of Schedule V drugs would carry a 1-year sentence. The transfer of marihuana, not for remuneration, would also carry a 1-year sentence.

Where a person over 18 sells drugs to a person below 21, the first offense punishment is twice that otherwise prescribed.

Where an individual engages in a continuing criminal enterprise involving a continuing series of violations undertaken by him in concert with five or more other persons and from which he derives substantial income, he is punished by a mandatory minimum sentence of not less than 10 years and up to life imprisonment, together with a fine of up to $100,000 and forfeiture to the United States of all profits derived from the enterprise.

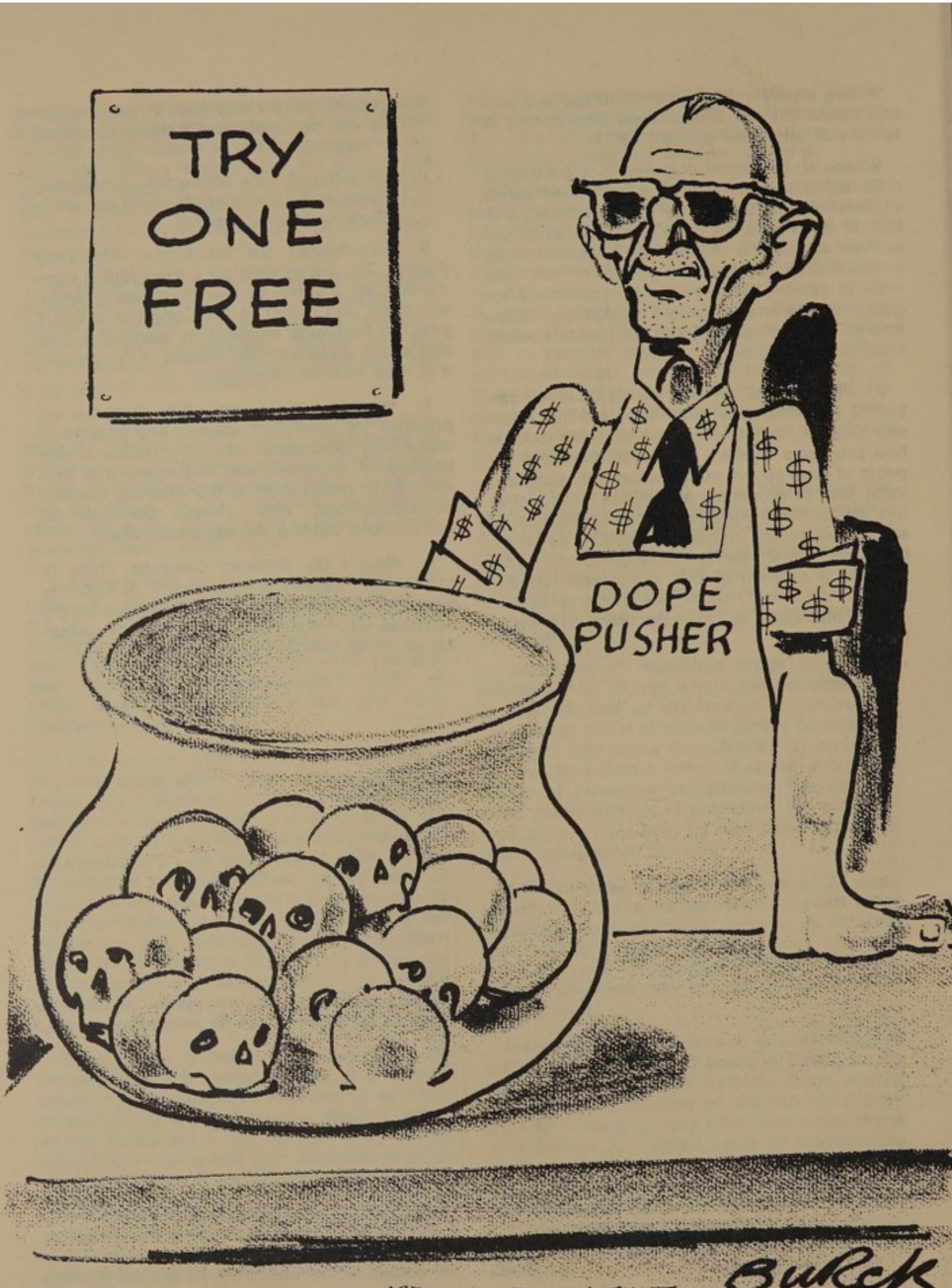
5. *Administration.* The bill specifies a number of administrative authorities for the Attorney General, authorizing research and education programs relating to law enforcement aspects of drug abuse, cooperation with state and local law enforcement authorities, administrative inspections, forfeitures, and execution of search warrants, including authority to enter premises without giving notice of authority and purpose if a judge or U.S. magistrate has authorized such entry in the warrant after determining that there is probable cause to believe that —

1. property sought may and, if notice is given, will be easily and quickly destroyed or disposed of, or,
2. the giving of such notice will immediately endanger the life or safety of the executing officer or another person.

6. *Commission On Marihuana And Drug Abuse.* The bill establishes a Presidential commission on marihuana and drug abuse which will study and report to the Congress within 1 year on problems involved in marihuana use, and within 2 years on the causes of drug abuse and their relative significance.

7. *Imports And Exports.* Title III of the bill provides for control of imports and exports of drugs subject to abuse through a system of registration of importers and exporters, and permits for or notification to the Attorney General of transactions, with criminal penalties for transactions outside the legitimate chain.

8. *Report On Advisory Councils.* Title IV of the bill requires the Secretary of HEW to submit an annual report to the Congress on the activities of various advisory councils established under certain Public Health Acts.



CORNER CANDY STORE

Chapter 2
THE DRUG PROBLEM

The Drug Revolution

We are a drug-using society. A large segment of our population looks to drugs to alleviate a host of psychological, physiological and social maladies. Young and old alike are inundated with commercial sophisms eulogizing drug products.

Drug abuse is many things. It is the heroin user injecting his bag of "H", the methedrine user high on "speed," the teenager smoking "pot," the 12 year old sniffing model airplane glue. But it is also the adult starting his day with an amphetamine or "upper" for a "pick-me-up," and ending it with several drinks to "unwind" and a barbiturate or "downer" to find rest at the end of a busy day.

The problem of drug abuse reaches intensely into our values, aspirations and fears. The loss of one's senses, the promotion of apathy, and flight from reality are alien to our American ethic. The horrible potentialities of a drug dependent society are as awesome as any Orwellian nightmare.

Drug abuse is not a new phenomenon. Varying forms of drug abuse have existed for years in the United States and other countries. It is, however, safe to say that the epidemic of drug abuse which surrounds us today and which has been called "the Drug Revolution" began in the mid-1960's. In the intervening years, every form of statistical measurement shows that drug abuse in Illinois and the nation has proliferated at a truly frightening rate.

There are many reasons for the Drug Revolution. They all, however, come down to a very simple understanding of the effects of the drugs themselves. Broadly speaking, drug abuse can be described as an effort by individuals to change the way they feel. Many drugs temporarily allow their users to evade frustrations, to lessen depression and feelings of alienation, or to escape from themselves. Such misuse of drugs, of course, does not produce an improve-

ment in the problems of the individual or society. In many cases, the use of these drugs represents a flight from the problems.

The following is a list of some of the reasons for the Drug Revolution suggested by the many persons who addressed the Commission during its year of study:

1. The wide spread belief that drugs can magically solve problems.
2. The large number of young persons who are dissatisfied or disillusioned, or who have lost faith in the prevailing social, economic and political systems.
3. The tendency of persons with psychological problems to seek easy solutions with drugs.
4. A general breakdown of authority.
5. The easy access to drugs of various sorts which has followed their tremendous over-production.
6. The development of an affluent society that can afford drugs.
7. The statement of proselytizers who claim the wonders and beneficial qualities of drugs.

Pervasiveness of Usage

The abuse of drugs in Illinois and elsewhere has become so rampant that a drug "culture" has been created. A drug culture or subculture is best understood as a group of persons whose lives are influenced or committed in varying degrees to drugs. The extent of commitment may be partial, as in the case of the suburban housewife who uses amphetamines to lose weight and barbiturates to sleep. Or the commitment may be complete, as in the case of the "speed freak" in Chicago's Old Town Area.

The location of users generally varies with the drug in question. Until recently, almost all heroin use was confined to males in urban ghettos. Now this pattern is changing. Young persons in suburban areas are turning more and more to heroin. Marihuana formerly was seen primarily in black disadvantaged areas, in certain Spanish-speaking communities, and in some groups of jazz musicians and other creative persons in the arts. Today, marihuana smokers and users of hallucinogens are found among middle and upper class youth and older persons such as businessmen and professionals. Barbiturates and amphetamines were once abused primarily by middle and upper class adults. Now, many youngsters of all classes are misusing them. Possibly they are following the drug abuse patterns displayed by their parents.

No one really knows how many drug addicts there are in this country. Recent estimates indicate that there may be as many as 300,000 heroin addicts alone. Most of the addicts are from four states. New York accounts for almost 50 per cent of the heroin addicts. An additional 25 per cent are located in California, Illinois and New Jersey. About 50 per cent of these addicts are between the ages of 21 and 30.

Estimates show the exent of abuse of non-narcotic drugs such as marihuana, hallucinogens, stimulants, and depressants exceeds heroin addiction several fold.

Cost to Society

Drug abusers drain millions of dollars from society. Initially, the very cost of the drugs themselves on the illicit market is exorbitant. The average heroin addict spends approximately $30 each day for his drugs. This means for 7 days a week, 52 weeks each year he would require about $10,950. Some of the hard heroin addicts require much more than this. Habits running up to as much as $100 a day are not uncommon. The habit produces a craving, and the addict must produce the money. Most of this money feeds directly into the organized criminal structure.

Because most addicts cannot legally obtain the cash to buy their drugs, they turn to crime. Most convert stolen merchandise into cash. It takes about $3-$5 in stolen goods to obtain $1 in cash. Thus, in order to support a $30 habit, the addict must steal $100 worth of property a day, or $36,500 a year (presuming he has no other source of income). Assuming all recorded addicts in the country use this method the Federal Bureau of Narcotics and Dangerous Drugs estimates that more than $2 billion worth of merchandise would be stolen to provide narcotics for this country's addict population each year.* This figure, of course, does not include the extraordinary number of thefts committed

* This is based on the figure of about 60,000 known addicts. However, the BNDD now estimates about 300,000 heroin addicts. This would mean a total of almost $11 billion of stolen merchandise, although it should be acknowledged that some addicts will sell heroin to sustain their own habits and do not steal every day.

by *non*-narcotic addicts. Nor does it account for the fact that other illegal means are frequently used to procure drugs. For example, female drug abusers frequently resort to prostitution in order to finance their habits. Forgeries, thefts of legitimate drugs and illegal production of drugs are also sources of illicit traffic and consumption of dangerous drugs.

John Ingersoll, Director of the Federal Bureau of Narcotics and Dangerous Drugs, recently estimated that the total drain on the United States economy caused by heroin traffic alone is as high as $3.5 billion a year. In an appearance before the House Select Committee on Crime, Ingersoll said that this includes the cost of crime committed by addicts as well as the law enforcement expenses. Although these latter costs would apply to law enforcement efforts against other drugs in addition to heroin, it is safe to say that the total drain on the economy produced by the full spectrum of drug abuse is much higher than the $3.5 billion cited by Ingersoll.

There is, of course, no way to measure the destruction of human life, health and happiness wrought by the drug abuser upon himself, his family, his community, and to society in general. This is the greatest "cost factor" in the long list of the ravages suffered by society in the "Drug Revolution." No price tags can be placed on deaths due to overdoses or on lives ruined because of drug experimentation.

Additionally there is a loss of productivity attendant to drug abuse. As the drug abuser grows more dependent, he loses his desire to maintain a productive place in society. If he has a wife and children, they suffer the consequences of his loss of will. If he is able to maintain a job his income is diverted to feed his drug habit. It is usually only a matter of time before he becomes involved in a criminal milieu and acquires a police record.

The ultimate cost, of course, is loss of life. It is the final disaster—to the victim, to his family, and to society.

Deaths Due to Overdoses

During its year of study the Commission became increasingly concerned over the growing number of deaths due to drug overdoses in Illinois—particularly in Chicago.

Beginning in October, 1970, the Commission questioned all coroners in the State of Illinois. Our research covered the years 1965-1970. The following tables reflect our state-wide findings:

Table 1

Deaths From All Drugs

Type	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
Narcotics	13	13	20	46	91	106	289
Barbiturates	99	100	103	97	128	90	617
Amphetamines		1	1		1		3
Tranquilizers	2	7	13	7	11	5	45
Inhalants			1	5	2	4	12
Others	10	17	17	21	21	31	117
TOTALS	124	138	155	176	254	236	1083

Table 2

Deaths From Narcotics

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
Boone	2	3					5
Champaign				1			1
COOK	10	10	20	45	91	102	278
LaSalle	1						1
Sangamon						4	4
TOTALS	13	13	20	46	91	106	289

Table 3

Deaths From Barbiturates

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
Bureau					2		2
Cass					1	1	2
Champaign	1		1	1	1	1	5
Christian					2		2
Coles		1	4		1		6
COOK	83	94	89	87	106	71	530
Crawford					1		1
Iroquois		1	1	2		2	6
LaSalle	2		1	2	1	1	7
Livingston				1		1	2
Macon					2	2	4
Madison						1	1
McLean	2				2	2	6
Moultrie			1				1
Peoria	2	2	3	1	1	3	12
Pike					2		2
Rock Island	4	2	1		1	3	11
Sangamon	1		2	2	4	2	11
Wabash					1		1
Warren	1						1
Will	1			1			2
Williamson	2						2
TOTALS	99	100	103	97	128	90	617

Table 4

Deaths From Amphetamines

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
COOK			1		1		2
Effingham		1					1
TOTALS	0	1	1	0	1	0	3

Table 5

Deaths From Tranquilizers

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
Champaign	1			1			2
COOK	1	6	11	6	6	2	32
Macon					2		2
Marshall					1		1
McLean		1				1	2
Randolph			2				2
Rock Island					2	1	3
Sangamon						1	1
TOTALS	2	7	13	7	11	5	45

Table 6

Deaths From Inhalants

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
COOK				4	1		5
LaSalle						1	1
McLean						1	1
Peoria			1		1	2	4
Rock Island				1			1
TOTALS	0	0	1	5	2	4	12

Table 7

Deaths From Other Drugs

Counties	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*Totals*
Champaign	1		1	1	1		4
Clay						1	1
COOK	8	15	13	17	11	27*	91
Effingham	1						1
Macon						1	1
McLean					1**		1
Peoria			1				1
Pike					1		1
Rock Island				1	4***		5
Sangamon		2	2	1	1	1	7
Will				1	1	1	3
Woodford					1		1
TOTALS	10	17	17	21	21	31	117

* 4 deaths occurred in late December 1970 for which toxicologic test reports not yet received by Cook County Coroner.
** LSD.
*** 2 of these were from LSD.

It must be explained that the figures presented in the drug overdose tables of this Report are valuable for purposes of determining trends and relationships among the various figures. Taken individually, the figures cannot be presumed to be accurate. The Commission discovered early in its study that, in general, the record keeping practices and cause-of-death studies undertaken by the various county coroners' offices have been inadequate for making accurate statistical surveys. This is due in part to the fact that a cause-of-death analysis in an overdose case is very time-consuming and requires a relatively sophisticated laboratory procedure. In many of the smaller counties this procedure is simply out of reach in terms of both available equipment and available personnel. In fact, even in Cook County, the State's most populous county, it has only been since 1969 that the County Coroner, Dr. Andrew J. Toman, has been able to institute an efficient and reliable system for determining the cause of death of overdose victims and a record keeping system which affords easy access and reference. Central to this new system is a laboratory device known as a Gas Chromotograph Instrument which automatically tests blood and bile samples for every type of drug and then measures the amount present. Prior to the implementation of this device, cause of death determinations required a manual process which took weeks or even months to accomplish. The new system allows a determination within a few days.

Dr. Toman told the Commission that drug death statistics acquired through coroners' records are inherently incomplete, even in the best of circumstances. One reason is that there is still no reliable means of determining the exact nature of many substances once they enter the body, one of which is lysergic acid diethylamide (LSD), because they metabolize immediately upon entering the bloodstream. Secondly, there is no way to determine how many deaths are caused indirectly by drugs, such as crimes of violence, suicides, or automobile accidents. Finally, many of the smaller counties do not have the sophisticated equipment that is used in Cook County, and consequently their determinations of cause of death must be based on less reliable methods.

Tables 1 through 7, previously cited, reflected that a total of 121 persons died from drug overdoses in Cook County for the calendar year of 1970. However, in the spring of 1971 Dr. Toman released a report indicating that there were 277 such deaths, (the numbers within parentheses represent those contained in Tables 1 through 7, taken from our 1970 survey), as follows:

Narcotics		143	(102)
Morphine	138		
Heroin	4		
Cocaine	1		
Barbiturates		110	(90)
Amphetamines		0	(0)
Tranquilizers		2	(2)
Others		8	(27)
Quinine	3		
Salicylates	3		
Aspirin	1		
Chloral Hydrate	1		
Unknown		14	
Total		277	(121)

Dr. Toman reported on August 5, 1971 that there was a 10 per cent increase in drug overdose deaths for the first six months of 1971, as compared to the same period in 1970, as follows:

	First Half 1971	*First Half 1970*
Heroin and Morphine	59	46
Barbiturates	39	48
Other Drugs	17	11

The Chicago Tribune newspaper reported that:

> . . . Coroner Toman warned that Cook County could set another record in 1971 for drug-related deaths . . . Our statistics show an urgent need for a comprehensive educational program to warn of the dangers of drug usage . . . we also have seen a continued trend of mixing drugs with alcohol, which often has unpredictable and fatal results . . . The 20-30 year old category continued to have the highest number of overdose victims. There were 45 in that age group, while 11 victims were under 20 years. The remainder were over 30 years. In the last few years, more Caucasians than Negroes have died from drug overdoses, according to the coroner's records. That trend continued with drugs claiming the lives of 64 Caucasians, 47 Negroes, two American Indians and 2 Orientals . . . Toman said there were 94 deaths in Chicago and 21 in suburban Cook County. Toman cited an example of the drug abuse crisis by pointing out that 28 persons in Cook County died last April of drug and narcotics overdoses, the largest number for a single month since January 1, 1969.

Dr. Toman explained to the Commission that often it is not one drug alone which kills, but the drug in combination with other substances, such as alcohol. The mixture of drugs and alcohol often produces a "synergistic effect" which amplifies the normal effects of the drug. A common problem today is that most of the drugs sold on the street have been adulterated to such a degree that the abuser is no longer satisfied with the potency. The drug user, unable to afford greater quantities of the drug, will try to compensate for this dilution by taking alcohol or barbiturates in addition to the primary drug. When combinations of depressants are taken, the result is often fatal.

Another consequence of adulterated drugs is that the user rarely knows the strength or exact composition of the drugs he is taking. He may take a given dosage of adulterated drugs many times without harmful consequences, and then unknowingly acquire a purer supply which could kill him if taken in his normal dosage amount.

Barbiturate users run an additional risk. In some cases the drug user will have heard that the injecting of barbiturates will combine with the effects of narcotics to produce a stronger effect. Barbiturates, however, will not necessarily dissolve completely and there is a strong possibility that the undissolved particles will cause an embolus or blood clot and sudden death. In addition, many persons are unaware that barbiturates can be just as addictive as narcotics, except that withdrawal is extremely difficult and often proves fatal itself. A study of the above tables immediately indicates at least two things: first, the rapid rise in drug overdose deaths within the last five or six years; and second, the consistently high toll of barbiturate-related deaths throughout that period. A more detailed discussion of the properties of barbiturate drugs will follow in Chapter 6 of this report.

Perhaps the most tragic deaths which can be attributed to drug abuse are those involving young people who take their own lives because of their despair and repulsion to an addict's life style. Adolescence, even without drugs, is a trying, difficult period for every young person. It is a time when the search for identity and confusion about the future are at their highest, while maturity and the ability to cope with every day stress are just developing. When the horrors of drug addiction are added to these normal pressures life often becomes too hopeless, too burdensome to bear, and a tragic suicide results. The state was shocked late last year to read the account of an 18-year-old Joliet youth, Percy Pilon, Jr., who had taken his life by shooting himself in the head with his grandfather's shotgun because, as he said in a note left to his parents, drugs had ruined his life and it was impossible to undo the damage they had caused. He advised other young people to stay away from drugs altogether and get help if they needed it, adding: "Drugs have their small moments of happiness, but for each moment lies a century of sadness never to be removed."

Drug Abuse in Industry

Drug abuse is more aptly described as a "people" problem rather than a drug problem. People have been abusing drugs for centuries, although their objects of abuse have periodically changed. For this reason, leaders in commerce and industry have come to recognize drug abuse as a matter of urgent concern. And this concern is amply justified for business leaders, because as people become increasingly enmeshed in the entanglements of drugs their

life patterns are changed and their ability to perform is greatly hindered. What this means to the businessman is loss of productivity and ultimately loss of profits. A brief examination of the drug problem from the businessman's point of view will demonstrate the rationale for his concern.

The intimacy with which industry is involved in the drug crisis is apparent from every aspect of the problem. The people most likely to be having difficulties with drugs are in the age bracket of 20-30 years—the age of most junior executives and newly hired employees. Every person's role as an employee is of tremendous personal significance, as it is one of the two or three social roles which take up the majority of his time. Consequently, the needs of job satisfaction and intra-company compatability become vitally important. An influential factor in this compatibility is the phenomenon of "peer group pressure," that same force which causes people to do things they ordinarily would not do, simply to "get along" with their contemporaries and gain the feeling of belonging to a group. Peer group pressure, if it becomes a motivating force behind drug abuse, can spread the problem throughout a department or even an entire company, with financially disastrous results.

Of course, there are the traditional considerations raised by any employee's personal problems, similar to those generated by the abuse of alcohol, such as absenteeism, lack of productivity, and family and health problems. In addition, drug abuse raises a few new difficulties. First, few people can work and effectively support a drug habit. Most will find that the amount of money necessary can be raised only through illicit activities, and this makes them a major risk for involvement in theft. The proportions of this problem are staggering. John Ingersoll, Director of the U. S. Bureau of Narcotics and Dangerous Drugs, has estimated that since addicts must steal property worth 4 to 10 times the cost of their habit, the national cost due to drug-related thefts may be more than $2 billion annually.

Secondly, the drug abuser as an employee is a major risk of accidents to persons and property. There is no way to determine the actual dollar value of this risk, but it is probably very high since it involves not only medical costs and insurance costs, but also costs due to the obvious morale problem he causes with other employees. Another risk incurred by the drug-abusing employee is due to the inherently illegal nature of his activities, and that is the risk of blackmail. This blackmail can result in the theft of business property and possibly even business or trade secrets.

Industry's recognition of the problem of drug abuse has led to action on several fronts. A number of companies and organizations have sponsored or prepared publications which explain the nature of the problem and what business leaders can do to cope with it. Various community business organizations have held seminars and conferences on the subject of drug abuse where specialists in the field are available to answer questions and offer suggestions.

Most of these activities share a common conclusion: that each company must develop some form of drug abuse policy and establish the machinery necessary to implement it. The sophistication of such a policy will, of course, depend on the size and circumstances of each company, but, as a minimum, mangement should decide to make itself aware of the problems and its symptoms, and decide what steps it will take if drug abusers are found among its employees. It must then communicate these policy decisions to the employees so that there will be no misunderstanding of possible future actions.

The Chicago Association of Commerce and Industry (CACI), composed of about 5,000 members in the business communities of Cook and neighboring counties sponsored a conference in January, 1971 on the problem of drug abuse in industry. Prior to the conference a notice and questionnaire were sent to personnel officers of all member companies, but only 133 replys were received.

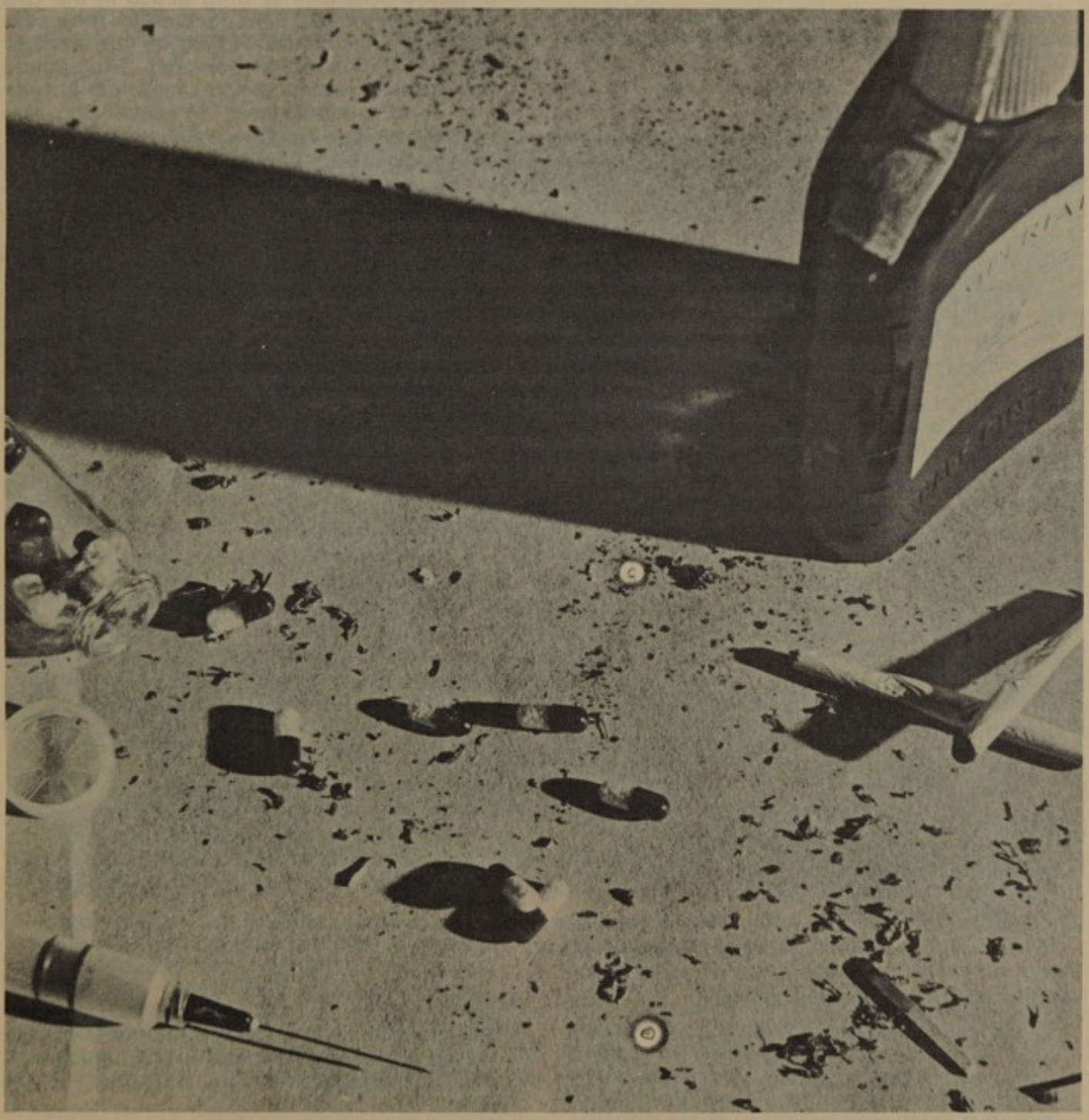
Following is quoted the CACI notice:

> Your Association is planning a conference on Drug Abuse in Industry for CACI member firms. In preparing for the conference a questionnaire has been completed and all companies are urged to complete and return it to the Association, as soon as possible. Individual replies will be kept confidential except to those on the Association staff who will be tabulating them.
>
> The growing problem of drug abuse and addiction is being recognized by companies throughout the country. Many executives say that drugs pose a far greater threat than alcohol. The primary weapon against this prevalent problem is knowledge. One very healthy fact emerging today is that business and communities openly discuss this difficult problem and have a universal desire to acquire information, develop policy and work together to overcome a growing menace.

Your help is needed. Will you please complete the questionnaire and mail it today to the Chicago Association of Commerce and Industry, attention: Health and Welfare Division.

Following is the content of the CACI questionnaire:

1. How many employees in your company?
2. What is your company's business enterprise?
3. Do you have a medical department, nurse, doctor?
4. Has your company detected any instances of drug abuse by employees during the period January 1, 1969 and November 30, 1970?



The use of marihuana, stimulants, alcohol and even heroin by workers is fast becoming a problem that business will have to face head on, according to authorities.

If the answer is yes, what type of drug abuse has been detected, marihuana, heroin or other hard drugs, depressants, or stimulants?

5. Does your company have a policy regarding drugs? If yes, is it formal or informal? If formal, please attach a copy.
6. Do you screen or are you planning to screen prospective employees for drug addiction? If so, by urinalysis, complete medical, or other?
7. Do you have an educational program on drug abuse for management, supervisors or employees?
8. Do you have a rehabilitative drug abuse program for employees?
9. Should you find an employee abusing 'hard' drugs (heroin) would you dismiss him if he is under the influence, in possession, or selling?
10. Would you discipline an on-job marihuana user? How, by warning, or dismissal?
11. Would you discipline an off-job marihuana user if it came to your attention? How, by warning or dismissal?
12. If one of your employees were selling marihuana or other drugs on company premises would you ignore it, warn him, dismiss him, inform the police, or what other action?
13. Has your company traced in-company theft to drug abuse?
14. Would your company keep an alcoholic on your payroll if his job performance is satisfactory, or if he agrees to seek professional help?
15. Would your company keep a drug addicted employee if he agreed to participate in a rehabilitation program, or a methadone maintenance program or other program?
16. Does your company provide your supervisors with oral and or written information for detecting drug abusers?
17. Other comments?

Mr. Ralph R. Springer, Director of the Urban Development Division, CACI, furnished the Commission with the following report:

> The Chicago Association of Commerce and Industry conducted a drug abuse in industry conference in January 1971. To help industry better understand the problem of drug abuse and what companies are doing about the problem the day's session was divided in two parts. The morning portion covered "The Medical Aspects of Drugs" while the afternoon session was devoted to "Developing a Company Policy."
>
> It is interesting to note that at both sessions the speakers brought out that although the drug abuse problem is growing, alcohol is still a greater problem.
>
> Prior to the conference a survey questionnaire was included in the CACI package to its members. Of the 133 replies received 27% of the companies reported they had detected instances of drug abuse in the two year period (1969-1970) covered by the questionnaire. Marihuana was by far the number one type of drug abuse detected. Drug abuse was more prevalent among male employees that female employees. In answering the question "Would you discipline an on-job marihuana user?" 52% reported they would take action to dismiss those using it. Some indicated they would first warn the individual, but if this did not corect the problem, dismissal action would be taken. Selling of drugs was considered much more serious and on this question 69% replied they would dismiss employees selling marihuana or other drugs on company premises. In-company theft to support drug abuse did not appear to be much of a problem. Only 4.5% reported that their companies had traced in-company thefts to drug abuse and all these were minor.
>
> Companies are developing policies on drugs. The following policy statement was developed by one of the Chicago companies:
>
> > The use of any drug interfering with safe and efficient job function is a matter of company concern and will be dealt with in an appropriate manner. Possession or use of illegally obtained drugs on the job or company premises may be cause for dismissal. Alcohol is also a drug about which there is serious concern, even though it is legal. Its use will be considered in the same manner. The company recognizes that drug misuse may be a serious medical problem. A rehabilitation program is offered in the medical department. Employees participating in a clinically supervised rehabilitation program will be eligible for benefits.
>
> In approaching the drug problem some companies have comprehensive educational programs for all their employees. This includes movies about drugs, articles in company newspapers, mailing of appropriate literature on the subject to the homes of all employees, and educational meetings for their supervisors.
>
> Perhaps the most complete guide to drug abuse planning and decision making is a pub-

lication entitled "Drug in Industry," published by Halos and Associates, Inc., Medical Book Division, 9703 South Dixie Highway, Miami, Florida 33156. Another work which would be helpful in making policy decisions is entitled "Drug Abuse as a Business Problem", published by the New York Chamber of Commerce, 65 Liberty Street, New York, N. Y. 10005.

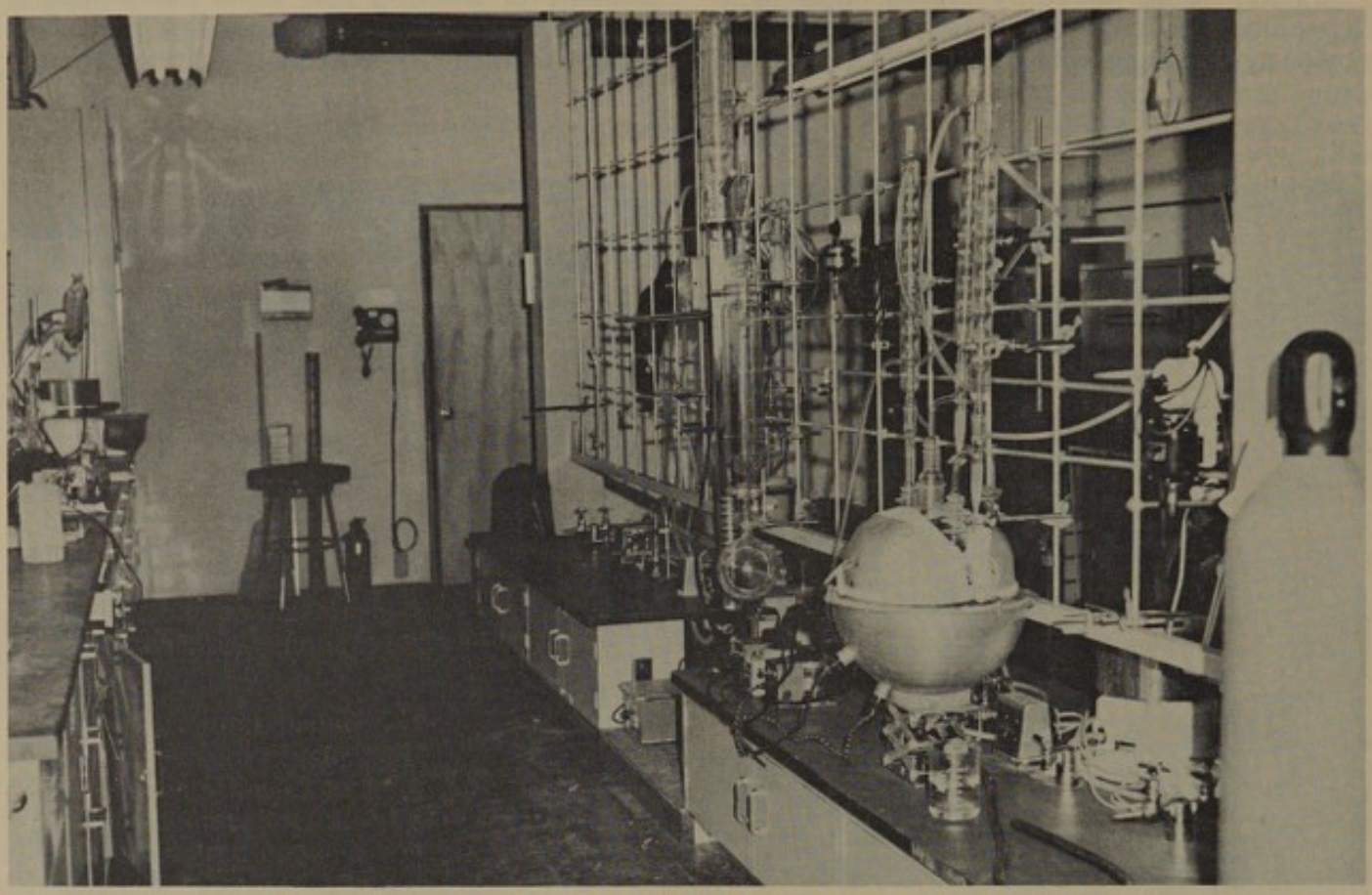
Drug Abuse in the Military

Although drug abuse by United States military personnel is directly a federal problem, it obviously has repercussions in Illinois as men are released and sent back to their homes. By far the most serious aspect of the military's problem is the reputedly drug-saturated environment in Viet Nam where young soldiers are first introduced to the habit and where this habit develops until they often become hard-core heroin addicts. Marihuana is the most commonly-used drug among U.S. personnel in Viet Nam, and some authorities estimate that up to 80 percent of our GI's have tried it at least once. The popularity of marihuana in Viet Nam can be explained by its inexpensive cost, easy availability, the boredom of the soldiers when they are not in the field, and the lack of effective sanctions against persons caught using the drug. Marihuana grows wild in Southeast Asia, and "joints" or marihuana cigarettes can be purchased for 10 or 15 cents each. There is no standard punishment for smoking pot. What punishment is meted out depends on the circumstances, but most often officers and enlisted men look the other way when they discover marihuana being used.

A large supply of stimulants, depressants and hallucinogens are seized in an illicit laboratory.

But profuse marihuana smoking is not the major drug problem facing the military. The same set of circumstances which encourages marihuana use also acts to initiate and encour-

age experimentation and, ultimately, addiction to heroin. The ready availability of heroin in Viet Nam makes the country a drug user's paradise. Addicts there can easily and cheaply procure supplies of heroin which would cost $75.00 to $100.00 a day in the United States, and that is why allegedly many addicts volunteer to extend their tours of duty in that country.



This clandestine laboratory manufactured illicit stimulants, depressants and hallucinogens.

One of the most direct consequences of this large-scale heroin use is a high death rate from overdoses. Although its records are admittedly incomplete, the Army has revealed that there were at least 75 heroin deaths between August 1 and October 18 of last year. One reason for the high death rate is that the heroin sold in South Viet Nam is 95 to 100 percent pure, while in the United States it is adulterated to only 4 to 12 percent of full potency.

Until rather recently, the Army has taken few positive steps to halt the burgeoning heroin problem. Disciplinary measures and an amnesty program have proven ineffective, largely because of a lack of treatment facilities or poor follow-up procedures. Addicts who are sent for treatment are usually detoxified and then sent back to their units where they are once more surrounded in a drug atmosphere.

When the magnitude of the military's drug problem became the focus of public attention, a program was established wherein military personnel returning from Southeast Asia would have to submit to chemical detection facts to determine if they have been using narcotic drugs. On the mandate of the President, the program calls for the development of treatment facilities where detected addicts may be sent to undergo rehabilitation before being released from the service. President Nixon called on Dr. Jerome H. Jaffe, formerly the director of the Illinois Drug Abuse Program, to supervise this massive rehabilitation attempt.

The impact of the military's drug problem must be taken into account when appraising the prob-

lem in Illinois. Certainly, the State should support the attempt the Federal government is making to prevent the influx of hard-core addicts into the State through its rehabilitation programs. Hopefully, the Army's experience may provide valuable research data which can eventually be applied to solving the well-entrenched domestic drug dilemma.

The Commission was pleased recently to learn that the Illinois Drug Abuse Program is seeking to contract with the United States House of Representatives Committee on Veteran's Affairs to provide care for heroin-addicted Illinois Viet Nam veterans. In a letter to Representative Roman Pucinski, Dr. Edward J. Senay, Director of the Illinois program, indicated his agency's interest in aiding veterans with a drug problem and suggested that one means of assistance would be to provide the hospitals with experts. Representative Pucinski is a member of the House Committee on Veteran's Affairs.

We were recently informed that in and out-patient services for heroin-addicted returning Viet Nam veterans will be opened within the year at Hines, Downey and Research Veterans Administration Hospitals, in addition to the service now available at Chicago's West Side Hospital. Dr. Senay has indicated that his agency is encountering difficulties in finding and training staff for the various programs. Currently the Drug Abuse program is treating 36 veterans.

In a resolution introduced in the Illinois House last July 16th by Representatives Merlo, Shea, Hyde and others, and unanimously approved, the Illinois Dangerous Drugs Advisory Council was directed to establish a special task force to investigate drug addiction among returning veterans. The Council was further directed to prepare and submit an interim report to the General Assembly during the Fall of 1971 session and a full report by February 15, 1972. This Commission eagerly awaits these reports. They represent a significant example of the type of research that is needed in all aspects of the drug problem.

Chapter 3
THE YOUTHFUL DRUG CULTURE

Youth and Drugs

Drug abuse can properly be characterized as a practice engaged in primarily by young people. Figures from the Federal Bureau of Narcotics and Dangerous Drugs show that 47 per cent of the narcotic addicts in this country are between the ages of 21 and 30. There is increasing evidence that many drug abusers are introduced to the practice in high school or junior high school.

Mr. Edward Hanrahan, Cook County State's Attorney, testified at the Commission hearings that the average daily load in the Cook County Narcotics Court was 400 cases, 70 per cent of which involved marihuana and of these 50 per cent of the marihuana users were under 25 years of age. A survey conducted by the National Institute of Mental Health last year showed that almost one-third of all college students had tried pot, and approximately 14 per cent used it regularly. A more recent survey conducted by *Playboy* magazine indicates that *current* use may be as much as double those estimated by the NIMH.

A sobering indication of the rise in *hard* drug abuse among the young is found in the statistics of the Cook County Coroner's office: in the first six months of 1971, there were 115 drug overdose victims, 45 of whom were in the 20 to 30-year-old category; 11 were under 20 years of age and those remaining were over 30 years old.

There is no simple explanation why young people, as a group, are more vulnerable to the drug abuse syndrome than older age groups—it is a complex phenomenon.

John Finlator, Associate Director of the Federal Bureau of Narcotics and Dangerous Drugs, in discussing the possible reasons behind youth's enthrallment with drugs said that in addition to boredom, "kicks", and the urge to defy authority,

> . . . there are some mature reasons why young people resort to drugs of abuse: pressures from the world around them, such as

the necessity for getting good marks in school to keep mom and dad off their backs, the need to score high on college boards or else it's in the Army, or the need to finish in the upper quarter or never make graduate school. There are other pressures in the affluent society over which the young person is not his own master. Things like conforming to the proper mores, ranging from the choice of a wife to landing a good job or belonging to the right club. In the advanced stage of youth, the person who has not 'made it' may resort to halluncinogenic drugs because he wants to better understand himself, to find out what's wrong with his personality, or to be more creative.

Still another piece to our puzzle . . . is that age-old characteristic, curiosity. So much has been written, spoken, painted, photographed, and broadcast about turning on or turning off that the old cat just had to see for himself—and sometimes the old adage about curiosity proves true—it kills him.

Some psychologists postulate that drug abuse is a product of the rebelliousness and discontent of the young generation. To some users drugs represent an external manifestation of their rejection of middle-class values and society in general. Others, caught up in an era of growing permissiveness use drugs to shock or enrage their parents. As one psychiatrist says: "Taking drugs is one way of tweaking the old man's nose."

Many users of pot or other drugs simply find them enjoyable, as many people do with alcohol. Others may find that drugs offer a convenient way to escape an uncomfortable or unbearable reality. The quest of the "now" generation for mystical insights and experimental titillation may induce some young people to experiment with the "mind-expanding" drugs, especially marihuana and hallucinogens such as LSD.

Dr. Daniel X. Freedman of the University of Chicago proposes youth's impatient desire for sensual gratification and emotional experience as contributing reasons:

Early arrivals at the Heyworth Rock Festival, at Kickapoo Park, nine miles south of Bloomington near Heyworth, Illinois, set up camp. The festival drew both single and married young adults, including many children.

Tents and other make-shift "housing" having been set up, the first persons to arrive at the festival bask in the morning sunshine.

Our society is mobile, and acting up is a ready substitute for isolation, depression, and mild despair. Many college students who have experimented with [drugs] seem to have an intense need to *feel*. They use drugs to establish a hitherto elusive contact with themselves and others. The seductive ease with which one can instantly change one's normal expectations and experience is a lure for others. The prolonged period in which the slow and painful acquisition of competence is demanded from an intrinsically impatient age group also plays a role.

Curiosity about the mind—about what can be experienced and about knowing who one is and is to be—can be expected. All the crises of adolescence—the fluidity, shifts of roles and expectations, search for identity, differentiations from parents—play into the drug-taking culture. Parents can be defied, as the frustration of years of inexperience is reversed by an intense drug-induced subjective experience which parents have not had.

Dr. Dana L. Farnsworth, in a paper presented to the 1969 National Governor's Conference on Drug Dependence and Abuse, in East Lansing, Michigan, asserts that today's adolescent is reared in an atmosphere of tumultuous change and abandonment of traditional values:

He lives, also, in a world which has exploded in technological skill but has had no corresponding increase in understanding of human needs. The old structural institutions of family, church, and community have lost much of their influence, and no way has been found yet to reestablish them or to create meaningful new social institutions. Publicity by the mass media spotlights the bizarre, the violent, and the psychopathological, until often they are taken as the norm. Adolescent purchasing power has increased and restrictions have decreased. Permissive modes of child rearing have confused both young people and their parents as to what is expected of them. Because their parents give them little responsibility, they do not know how to take it and are unwilling and afraid to assume any. A marked and dramatic change has overtaken what used to be considered acceptable in speech, manners, clothes, and in entertainment and communications media. Vigorous attacks on the 'Puritan ethic', originally motivated by the very real defects and excesses of this point of view, have progressed to rejection of all its components, good and bad. Attitudes towards sexual morality

have undergone radical changes, and in many groups behavior has changed as well. The trend toward immediate gratification of impulses has become stronger, and postponement of gratification is often considered futile.

. . . Peer group influence often leads even basically cheerful young people to think in a pessimistic manner, and may contribute to drug use by creating an atmosphere of hopelessness and negativism. When group identification and shared experience include initiation into drug use, even young people who ordinarily would not consider taking drugs find that the pressures on them to conform are imense. . . .

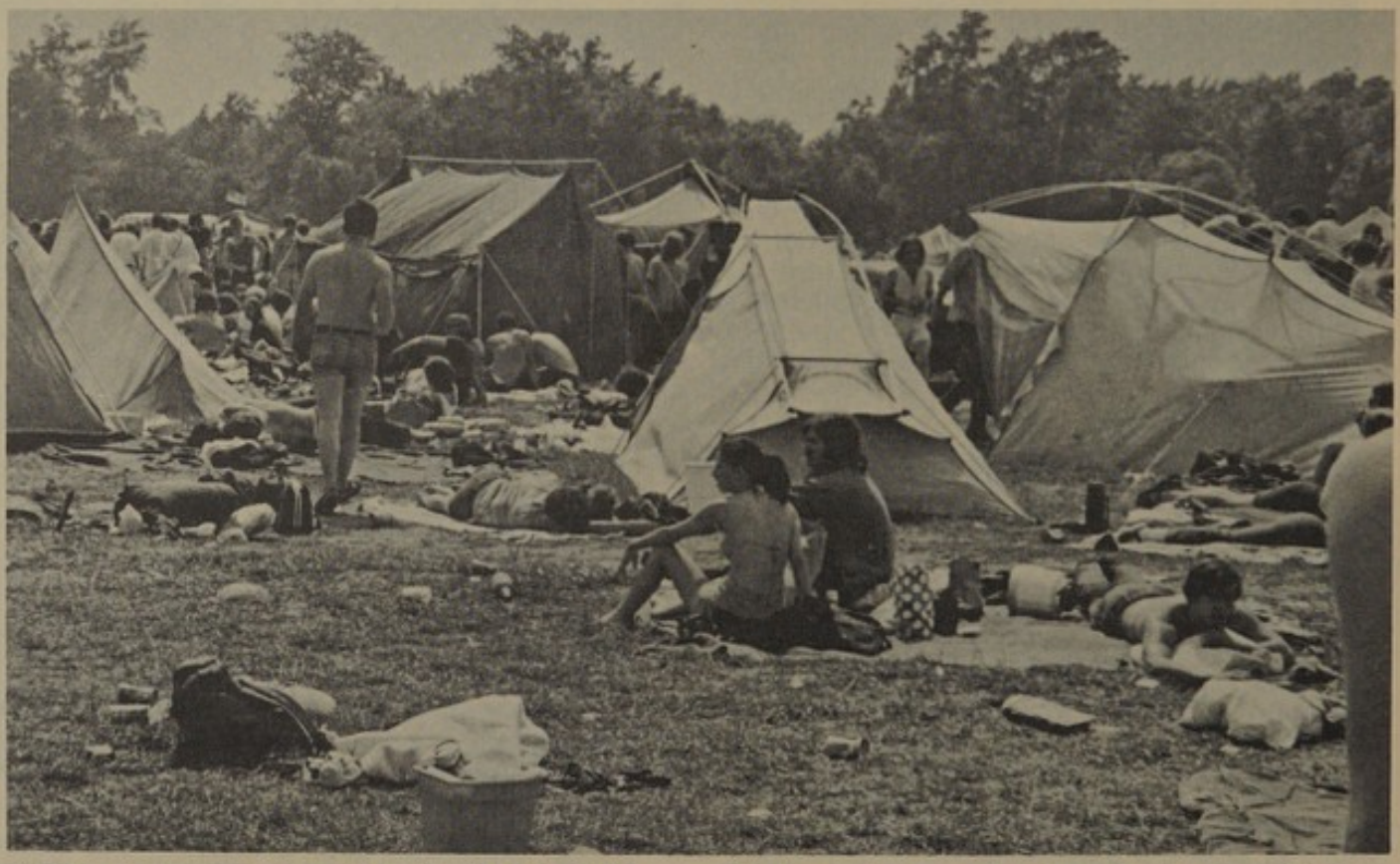
It is possible, therefore, that if drug taking were no longer condoned by most young people, the users deprived of the gratification of peer approval, would turn to other ("ideally more constructive") methods of dealing with their personal problems.

Dr. Joel Fort, noted author and specialist in public health, drug abuse and youth problems offers the following:

There are many reasons why people use drugs. We live in a drug-ridden, drug-saturated society where from infancy we are taught that "better living through chemistry" is where it's at. The adult example of always socializing through alcohol, tobacco, or other drugs, and seeming to have a good time only when drugs are involved is massively communicated to children as they grow up. This indoctrination is strongly supplemented by the millions spent each day in advertising alcohol, tobacco, and over-the-counter pseudo-sedatives to foster the earliest possible use of drugs in the greatest possible quantities. And the sensationalistic attention given to marihuana and certain other drugs by certain agencies of our society constitutes less formal, yet very powerful, promotion.

Significant factors in drug use and abuse in America are:

1. Practically all the mind-altering drugs are available either legally or illegally.
2. The desire for simple, quick solutions.
3. The symbolic value of many drugs with respect to the generation gap.
4. Pressure within the peer group to be "in" through the use of alcohol, tobacco, marihuana, etc.



As the day wears on at the festival in Kickapoo Park, garbage and refuse begin to collect.

Youths mill about the stage area waiting for the first of the scheduled rock concerts.

5. The quest for pleasure and the false belief that such pleasure comes only through drugs or will always derive from them.

6. The absence of alternatives in many people's lives so that they see "no hope but dope."

7. The criminalizing effects of our laws which attempt to deal with private behavior, and to coerce morality through criminalization.

8. The pervasive and growing alienation of our population.

Dr. Jerome Jaffe, former director of the Illinois Drug Abuse Program, has blamed the mass media for much of the impetus of the "drug revolution" because their coverage and commentaries concerning drug culture phenomena tend to glamorize the abuse of drugs and bring the drug-oriented life style in vogue. Doubtless there are probably as many reasons, or excuses, for drug abuse as there are drug abusers. Together they form the foundation of what has become known as the "drug culture", and, notwithstanding these diverse personal motives prompting drug abuse, it is important to study the outward manifestations of the "culture" to get a better understanding of the total phenomenon.

Music

Our current era of booming technological progress has made music a vitally important factor in the life styles of our youth. They are inundated by popular music wherever they go, from transistor radios, home stereo equipment, live concerts, automobile tape decks or the ubiquitous juke box. This constant exposure assures that if there is a message to today's popular music it will be communicated, and it will, in many cases, be influential in forming the thoughts and ideas of its listeners.

Much popular music has, within the past seven or eight years, adopted a social conscience, or stated a "message." Many popular songs speak of war, environmental pollution, disparity among the races, poverty—and drugs.

The songs about drugs fall into two classes. The first group actively promotes the use of drugs while the second preaches against them. Encouragingly, most of the newer songs such as "Bridge Over Troubled Water" and "One Toke Over the Line" fall in the latter category.

A substantial controversy has arisen over the effects of the pro-drug songs on American youth. Many have agreed that these songs do not, in fact, consciously encourage the use of drugs. Rather, they are nothing more than commentaries on already existing situation. Others have

asserted that children in the teen years are highly impressionable and tend to emulate those they admire. As examples they point to the hair styles and fashion trends which have supposedly been generated by rock stars such as the Beatles and the Rolling Stones.

The Commission has failed to perceive any cause and effect relationship between drug related music and the individual child's decision to take illicit drugs. We have, however, concluded that many of these songs provide an atmosphere of acceptability to drug use which, in combination with more forceful factors, may encourage the use of drugs. Further, we are sure that some misguided youths are sufficiently impressed with certain rock heroes and heroines that they may choose to emulate their life styles—even to the point of orienting their lives to drugs. Moreover, much of the rock music being played today is intended to duplicate the drug experience. This is particularly true of "acid rock" which, as the name implies, is intended to simulate the effects of LSD. Several rock groups have taken drug-related names. Examples include "The Jefferson Airplane" and "The Grass Roots"—both involve references to marihuana. Moreover, many rock theatres employ light shows and other visual effects which are obviously intended to recreate drug hallucinations. Finally, the use of drugs by musicians and audiences alike provide further evidence of a link between the music and the way it is intended to be best appreciated. The use of marihuana and other drugs, at such "rock palaces" as Fillmore East and West, and formerly at Chicago's Aragon Ballroom, and the now defunct Kinetic Playground, are too well established to deserve further mention. The drug nightmares which have taken place at rock festivals across the nation are similarly well established.

Most of those who attended the festival May 28-31 would be classed as youthful "hippie" types.

The songs themselves, however, have generated the greatest controversy. Several examples of the allegedly pro-drug song lyrics

which were considered by the Commission in the course of its public hearings are contained in Appendix 17 of this report. The concern of this Commission was recently reflected in a public notice by the Federal Communications Commission to its licensee-broadcasters. The entire text of this notice follows:

LICENSEE RESPONSIBILITY TO REVIEW RECORDS BEFORE THEIR BROADCAST

A number of complaints received by the Commission concerning the lyrics of records played on broadcasting stations relate to a subject of current and pressing concern: the use of language tending to promote or glorify the use of illegal drugs such as marihuana, LSD, "speed", etc. This Notice points up the licensee's long-established responsibilities in this area.

Whether a particular record depicts the dangers of drug abuse, or, to the contrary, promotes such illegal drug usage is a question for the judgment of the licensee. The thrust of this Notice is simply that the licensee must make that judgment and cannot properly follow a policy of playing such records without someone in a responsible position (i.e., a management level executive at the station) knowing the content of the lyrics. Such a pattern of operation is clearly a violation of the basic principle of the licensee's responsibility for, and duty to exercise adequate control over, the broadcast material presented over his station. It raises serious questions as to whether continued operation of the station is in the public interest, just as in the case of a failure to exercise adequate control over the foreign-language programs.

In short, we expect broadcast licensees to ascertain before broadcast, the words or lyrics of recorded music or spoken selections played on their stations. Just as in the case of the foreign-language broadcasts, this may also entail reasonable efforts to ascertain the meaning of words or phrases used in the lyrics. While this duty may be delegated by licensees to responsible employees, the licensee remains fully responsible for its fulfillment.

Thus, here as in so many other areas, it is a question of responsible, good faith action by the public trustee to whom the frequency has been licensed. No more, but certainly no less, is called for.

FCC Commissioner Nicholas Johnson dissented strongly from the majority opinion, alleging that the Commission's announcement was no more than a thinly veiled attempt to censor song lyrics in violation of the First Amendment

Virtually every form of vehicular transportation was used to get to the festival. All of it was channeled along Illinois Route 51, a two lane asphalt highway.

Several very young children were drug victims, such as this one, whose mother tries to comfort him. Earlier the man the mother was staying with had given the child some chocolate which contained an unidentified psychedelic drug. Instances of parents administering drugs to their children at such festivals are quite common.

right to free speech. The various broadcasters, unsure of the exact import of the announcement, demanded a hearing for settling the constitutional issues and for a clarification of the Commission's position.

On April 16, 1971 the FCC repeated its major point that broadcasters have a responsibility for knowing the content of the records they play on the air. It stressed, however, that the public notice was not intended to bar the play of certain records.

A few of the nation's broadcasting stations have volunteered to delete records and songs which encourage or promote drug use. In addition, on April 6, 1971, the president of MGM Records, Mike Curb, announced that his firm will not release any records advocating the use of drugs. He indicated that there is a growing trend within the industry to regulate itself against the promotion of the theory that these songs do have a causal impact on the drug crisis.

Of course, there are many in the broadcasting industry who strongly oppose the belief that lyrics have any such causal effect. Mr. Gene Taylor, General Manager of WLS Radio, Chicago, urged the Commission that song lyrics reflect social conditions, but do not cause them.

On April 15, 1971, the *Rolling Stone*, a tabloid newspaper considered to be the leading rock-music paper in the nation, published an article referring to the Commission's public hearings where the subject of rock lyrics was discussed. The article's general tone was one of deprecation as it listed some of the popular songs which were discussed and a synopsis of the comments made about the lyrics of each. Obviously, the *Rolling Stone* shares the belief of Mr. Taylor of WLS that song lyrics have no causal effects on the drug problem.

Rock Festivals

Perhaps one of the most overt demonstrations of the relationship between drugs and popular music is the phenomenon of the "rock festival." These are live-performance extravaganzas which may go on for more than a week and sometimes draw hundreds of thousands in attendance. Promoters will contract with numerous rock groups to perform during the festival, and arrange for the activities to be held in some open area where there are minimal and frequently inadequate facilities to accommodate the basic needs of the throngs of people who attend.

The most famous of these was the "Woodstock Festival" held in August of 1969 at White Lake, New York. This event later became the subject of a major motion picture entitled "Woodstock" which played at premium prices throughout the country. Since that time similar events have been held, some in our own state.

The "rock festival" probably had its genesis in the earlier forms of outdoor musical expositions such as jazz festivals and folk festivals, such as those held at Newport, Rhode Island and Monterey, California. What sets the rock festival apart from these early forerunners is not so much the performance of the musicians as the performance of the audience. Drugs, nudity, open sexual expression, and often violence have become the unfortunate trademarks of the rock festival audience.

Furthermore, Mr. John G. Evans, Regional Director of the Bureau of Narcotics and Dangerous Drugs, offered positive testimony concerning the possible influence of organized crime in Illinois rock festivals. Of course, whenever generalizations are made about groups as large as these there are bound to be unfair implications—a minority can make the reputation for the entire group. However, never before have promoters made such elaborate preparations to aid their law-breaking clientele, and never before have the participants responded with such open debauchery.

The largest rock festival held to date in Illinois was the Heyworth Rock Festival, held at Kickapoo Park, nine miles south of Bloomington, Illinois. Two Illinois State Policemen who attended the event testified at Commission hearings that an estimated 75 per cent of the crowd was using one or more types of drug. Tent facilities were erected in which drugs were manufactured and dispensed. Medical facilities were established to care for overdose victims or people who were having "bad trips." They stated that there were a number of small children in attendance with their parents and there were signs that these small children had

Kickapoo Creek was the scene of considerable frolic and merriment during the course of the festival. The Creek is located on the perimeter of the park.

also been given drugs. The motion pictures, and still photographs which the two officers introduced as exhibits and which are reproduced in this Report, amply demonstrated the tent facilities referred to earlier and the open nudity and sexual misconduct of the audience. They also testified that peddlers of drugs would walk throughout the crowd openly selling bags of marihuana and various pills.

Festival stated that there were no arrests made on the festival grounds in spite of the open illegal conduct for fear of inviting either personal physical harm to the arresting officers or a mass exodus to and destruction of the neighboring small communities.

The relationship between rock festivals and drug use is overt and notorious. The festivals

Residents of "Kickapoo City" look on as someone "does his thing." Numerous American flags were flown upside down as a form of political protest.

There were numerous reports of beatings by members of motorcycle gangs who came to the festival from Chicago and Milwaukee. It was reported that they had taken over the security jobs around the festival site, depriving the promoters of $30,000 from the total gate. In a similar incident in California last year, members of the Hell's Angels motorcycle gang murdered a member of the audience in front of the stage in the course of a performance. It was estimated that 50,000 to 60,000 persons attended the Heyworth Festival. Prices were $10.00 per person in advance or $15.00 at the gate. There is no evidence that the promoters of rock festivals arrange for the presence and sale of drugs at the events. But certainly they are powerless to stop drug use under the conditions which prevail at these events. Indeed, the two officers who attended the Heyworth

provide a gathering place for members of the counter-culture where they find understanding and, perhaps, strength from their fellow members. It is becoming common knowledge that at these festivals drugs can be used and flaunted with relative abandon and aberrations of traditional sexual mores meet with tolerance, if not approval.

The music played at these festivals most likely has the effect of encouraging these uninhibited activities. The lyrics, as mentioned above, often contain overt or thinly veiled drug messages; but perhaps more conducive to drug use are the performers themselves. As indicated above, live performances by artists of the "acid-rock" genre are intended to be non-chemical duplications of a drug "trip," and become more profound and more hallucinatory

when the listeners are actually under the influence of some drug. The suggestive and bizarre dress and appearance of the performers, the ultra-high powered amplifiers, the discordant melodies, and the heavy beat of drums and bass all contribute to the illusion of an hallucinatory experience. Often, multi-colored strobe lights are added to heighten the effect. Many times, between or during numbers, the performers will narrate encouragement to "get high," and their suggestions under those circumstances are highly influential. Occasionally band members will expose themselves to audiences. One example is the late Jim Morrison, of "The Doors." Total nudity by performers is not uncommon. Some groups have been known to reach such a fever pitch that they destroy their instruments in a music frenzy. An example of this phenomenon can be seen in the Alice Cooper Band.

With regard to this latter point, something should be mentioned about the tremendous influence "rock stars" have on their audiences. There have always—or at least for the past 50 years—been instances when musical performers have been idolized by their listeners. Some can recall accounts of thousands of women swooning over Rudy Vallee, and later Frank Sinatra, and then Elvis Presley, and more recently the Beatles and other rock performers. But there is a notable difference in the modern deification of performers. The modern stars are younger, come from more common backgrounds, and get far more exposure through the media. As a result they have sometimes become the leaders, the trend setters and the life-style vanguards of the young generation. They are more vociferous in voicing their views on politics, war, race relations, and other topics far removed from show business. They can more easily be identified with by members of the young public because their dress, jargon, and life style are similar to their own. When this empathy is combined with the emotional excitement of a rock performance, the performers may achieve total control of their audience.

The life styles of these performers have been publicized and carefully followed by our youth. They are aware that many performers use drugs and advocate their use to others. The deaths of Janis Joplin, Jimi Hendrix and Brian Jones were shocking, but the fact that they died from drugs was not. It is impossible to determine how many young people have turned to drugs as a direct result of the suggestions or rock stars, but their impact certainly cannot be ignored. The Commission would suggest to these performers that they take a responsible recognition of their positions as leaders of the young generation and turn their influence to constructive endeavors. In similar fashion, they must share the responsibility for the destruction of lives they cause through their advocacy of drug abuse.

Head Materials

The rising popularity of marihuana and other hallucinogenic drugs has been accompanied by a proliferation of devices and materials which are used in conjunction with the drugs, as well as stores and shops where these items may be purchased. Generically, these devices and materials are known as "head supplies" and they are sold in "head shops". The term "head" refers to the effect of marihuana and hallucinogenic drugs on one's psyche and perceptive powers. The various paraphernalia found in head shops are intended for use with marihuana and hallucinogenic drugs alone. There is no such open market for items which are opiate-related.

The information which was obtained by the Commission on the subject of head shops was gathered by its Chief Counsel, Roger C. Nauert, who for 6 weeks carried on an undercover investigation of these establishments in the Chicago area. He discovered that the proliferation of head shops centered primarily in two areas: the Old Town community and the area along North Sheridan Road between Devon and Touhy

Drug sales and consumption were rife at the festival. Tent facilities were erected in which drugs were manufactured and dispensed. Many sellers operated out of their own vehicles.

Avenues. A few shops have also recently been opened in the Chicago Uptown District. This is largely attributed to the hegira of "hippie" type persons from the Old Town area because of the increased cost of living around Wells Street. There are virtually no head shops in the ghetto areas of the city because the stores are primarily identified with the new "hip" culture which is nearly all white and youth-oriented. Furthermore, in the ghetto areas the drugs of abuse more frequently tend to be the opiates or "hard" drugs for which head supplies are not intended.

Also present at the festival were groups which represent the antithesis of drugs and violence. Pictured here is a young member of a Buddhist sect frequently seen by Chicagoans along State Street in the Loop.

Mr. Nauert testified that head supplies could be classified broadly into two categories: usage paraphernalia and evangelization items. In the usage class are those items which are designed for use in administering or savoring the effects of drugs. These would include all smoking devices as well as all items which aid or exaggerate the sensory distortions caused by several of the drugs.

The second broad classification would include items which are designed to evangelize or extol the use of drugs, principally marihuana and hashish. This group includes wall posters, T-shirts, arm patches and political-type campaign buttons.

Mr. Nauert's investigation took him and an assisting agent to many of the various shops. He said that in no cases were they able to purchase actual drugs, and it was their impression that the head shop owners were unwilling to jeopardize their capital investments by openly dealing in drugs with shop customers. However, virtually all the shop owners and sales personnel were willing to freely discuss the use of marihuana and the paraphernalia which they sold. Furthermore, they all were happy to suggest locations where marihuana could be purchased from third parties. These locations were coffee shops, record stores, art galleries, and generally any of the local bars which featured folk or rock music.

Mr. Nauert purchased several representative items from the head shops and presented them as exhibits at a Commission hearing. These items included the following: (1) Packages of cigarette papers which are used to roll "joints" or marihuana cigarettes. The papers are thin and manageable and ideally should burn slowly to contain the gases and smoke created by the burning marihuana. The ends of the "joints" are twisted to prevent the seeds and leaves of the marihuana from falling out. The "Bambu" brand, made in Spain, is currently the most popular. "Zig-Zag" is another brand which is well-known. The package features an ink drawing of a bearded man smoking a cigarette. This image, "Mr. Zig-Zag," has become a symbol of marihuana proselytism. Some papers have designs or pictures printed on them, such as duplications of hundred-dollar bills or the American flag; (2) Water pipes, or "hookahs" which are used for smoking marihuana and hashish. The smoke from the burning marihuana is cooled by channelling it through a liquid medium, usually water. One proprietor explained that a better "high" could be obtained by filling the "hookah" with wine or other alcoholic beverages because of the complementary effect of alcohol with marihuana or hashish. Hookahs are made of wood, glass, or metal, and some come equipped with two or more smoke outlets for use by several persons at a single time; (3) "Stash bags" which are used by the "hip" culture to carry marihuana and smoking accessories. These range in price from cheap to very expensive and are worn on the carrier's belt. Most young people wear them openly, but they are also carried surreptitiously by businessmen and professional people under their coats; less ornate marihuana smokers keep their precious cache in cellophane cigarette bags or "baggies"; (4) "Hash pipes," which resemble ordinary small tobacoo pipes but are primarily designed to be used for smoking marihuana and hashish. These are made of brass, wood, stone, clay or glass. It

was explained that for many of these a small, one-half inch round copper screen is needed to be placed in the bowl of the pipe to prevent condensation of the smoke and extinguishing of the burning marihuana. Especially is this true for hashish because of its finer texture. The ideal pipe has a very shallow bowl. In smoking, the hand is placed over the bowl to prevent the tars and gases from escaping; (5) Incense burners, which are used to burn marihuana and produce the familiar sweet, rope-burning odor, creating a mystic aura in the room; (6) Cigarette rolling machines, which are manufactured for use with ordinary tobacco, but are sold in head shops with the distinct indication that they could also be used for manufacturing marihuana cigarettes. Some even provide for the attachment of a filter tip to the home-made cigarette, although it is doubtful that most marihuana users would sacrifice the precious tars and gases the filter would screen out; (7) "Roach clips," which are devices designed to hold the last half inch or so of a marihuana cigarette without burning the fingers of the user. This tiny cigarette butt (the "roach") is valued by the smoker because it contains the heaviest residue of tars and resins from the marihuana. These clips come in an assortment of sizes and styles, one of which is called the "Bullet for Peace," which appears to be an ordinary bullet. A closer analysis, however, reveals that a roach clip has been embedded in the casing of the bullet; (8) Multi-faceted eye glasses, which are worn to produce a tremendous distortion of light and thereby heighten the hallucinogenic effect of drugs; (9) Light machines, which produce a multi-colored stroboscopic effect and are used for the same purpose of visual distortion as the above mentioned glasses.

Common fare at the festival were marihuana, beer and inexpensive wines, all of which occupied prominent places at the festival as "cheap drunks."

The second class of head supplies, the evangelistic items, included the following: depictions of the familiar marihuana plant on posters,

T-shirts, buttons, etc.; plastic replicas of the marihuana plant; depictions of "Mr. Zig-Zag"; Army-type patches showing a five-pointed red star and a green marihuana plant superimposed thereon; various campaign buttons which have messages imprinted thereon which advocate the use and/or legalization of marihuana and other drugs, such as "Stamp Out Reality", "Turn On LBJ", "Acid", "Burn Pot Not People", "Stoned", "Head Power", "Let's Legalize Pot", "Equal Rights for Heads", "Hands Off Tim O'Leary", and "LSD Not LBJ". Similar messages are the subjects of posters.

The Radical Press

Nowhere is the youthful drug culture more apparent than in the radical press. Periodicals such as the Chicago *Seed* and the Los Angeles *Free Press* give continuous coverage to virtually all aspects of drugs and their relationship with young persons. Advertisments are carried for various head materials such as those described in the preceding section. In addition, ads are frequently run for legal, organic substances which are touted "legal" substances for marihuana and hashish.

As a part of his research, Mr. Nauert answered a number of these ads. In most cases the substances received were nothing more than harmless vegetable materials which have no euphoric or hallucinogenic effects whatsoever. The one exception to this was a packet of "Legal Hash" received from a company in Hollywood, California. Chemical analysis of the substance run by the Chicago Police Department Crime Laboratory revealed that it was finely ground catnip. Although not a controlled drug, in some circumstances catnip has been shown to produce mild psychedelic effects.

The advertisment appeared in an underground newspaper entitled *The Informer.* The paper is printed in Franklin Park, Illinois. The term "Legal Hash" is undoubtedly a derivation of "hashish" which is a highly condensed form of marihuana produced in the Middle East. The packet was received from a company known

Here a youth undergoes the agonies of an LSD "bad trip." Overdoses and "bummers" from hallucinogens and amphetamines were the most common medical problems encountered.

simply as "Winner," Box 48475-CN, Hollywood, California, 90048.

The company's advertisement read as follows:

> Legal Hash, turn-on guaranteed. Just like grass, cook or smoke it. $2.00 a lid makes 20 groovy joints. 3 lids/$5.00, 7 lids/$10.00. Dealers wanted.

The $2.00 lid mentioned above contained five grams of catnip. The pharmacological effects of catnip are discussed below in Chapter 6 of this Report. Enclosed in the envelope with the catnip was a pink, four-piece list of advertisements. Each ad listed a mailing address in the Los Angeles area. In addition to the advertisements for the legal hash already received, some of the brochures also advertised a "Trip-Out Book" which is discussed below. Additionally, the brochure contained seven advertisements for sex groups, sex correspondence groups, and a "Secret Report" dealing with a "101 Ways to Meet and Conquer Women."

The "Trip-Out Book" mentioned above was also purchased by Mr. Nauert through the underground newspaper ads. The book is a small greenish gray soft bound pamphlet with a blue series of concentric circles on the front cover of a psychedelic nature. The back cover contains the author's admonition that the data printed therein, "has been prepared for informational purposes and is not to be construed as an endorsement for the use of any of the end products described therein nor is it to be construed as a recommendation for its preparation or use."

The "end products" described in the booklet represent a wide range of dangerous drugs. In

Most bathers made frequent returns to the Creek throughout the day to wash themselves of the perspiration and grime produced by the settlement on the festival grounds.

the pamphlet the reader can learn how to prepare lysergic acid (LSD). Another section teaches how to synthesize mescaline, N,N-Dimethyl, Tryptamine (DMT), and tetrahydrocannabinol (THC). Another portion deals with morning glory seeds and the active ingredients of the peyote cactus, both of which have hallucinogenic properties.

The remaining sections are entitled: (1) "How to Grow Psilocybe Mushrooms," (2) "Powdered Bananadine Extract," (3) "Cannabis Extract," and (4) "Chemical Identification of Cannabis". The last page of the pamphlet contains a suggested list of articles dealing with marihuana and psychedelics such as mescaline. Interspersed in the booklet are various drug related ads referring to such items as "legal hash" described above, and nutmeg.

Also contained were several sex-related ads extolling the pleasures of wife-swapping, group sex, photograph exchanges, and orgies. Other sex advertisements refer to "correspondence" clubs and group sex clubs. Enclosed in the booklet also were two leaflets advertising sex and drugs. In the latter category was a small yellow card urging the reader to "GROOVE WITH LEGAL GOLD." This was succeeded with the following explanation:

> The effects of Legal Gold are similar to those of pot. Use it the same way pot is used. Roll it into joints or be really way out and cook with it. This package contains enough Gold to make 20 groovy joints.

The term "Legal Gold" is undoubtedly borrowed from "Acapulco Gold," an unusually potent variety of marihuana grown in the mountains surrounding Acapulco, Mexico. A quantity of Legal Gold was ordered but not received.

The original advertisements carried in the underground paper make the following promise:

> Turn-on with the famous "TRIP-OUT BOOK." Sure-fire formulas to make HASH from legal chemicals. Make peyote, DMT, cannabis, mescaline, LSD, etc. Do it now.

In addition to advertisements, the radical press has carried numerous articles on the drug problem. Although most of these articles have been favorable to drug abuse, several papers have carried anti-drug articles written by some of the leading drug authorities.

Similarly, many underground papers, notably the Chicago *Seed* frequently report prevailing prices for different drugs. Presumably this allows the drug user to determine whether or not he is getting a "bargain" for his money. The papers will also report on any unusual health hazards associated with the drugs being dispensed by a particular person or at a given location. Very often, drug sellers in attempting to make a sale, will lie about the ingredients of the drug they are trying to sell. For example, sellers have been known to sell mixtures of highly potent drugs such as combinations of LSD and such other dangerous chemicals as arsenic and strychnine, with the promise that it is "pure THC." Such combinations produce severe psychotoxic reactions. In some circumstances, death may result, or a sense of panic may ensue which causes the victim to take his or her own life.

Acting upon rumors and reports of such occurrences, underground newspapers will frequently run warnings describing the drugs in question, the sellers, and the locations at which they were sold. Although the Commission does not in any way condone the "boost" which these papers have given the drug revolution, we are satisfied that these latter warnings are prompted by a sincere humane interest in the health of those young persons who have chosen to take drugs.

The editors of the Chicago *Seed* were invited to appear before the Commission to speak on their role in the drug revolution. They declined the invitation. Apparently they were anxious to preserve the anonymity of the paper's editorial staff, and to avoid anything which might be construed as cooperating with "the establishment."

Life Styles

The life styles of youthful drug abusers are as varied as the drugs they take. The heroin "junkie" usually leads an existence far different from that of the marihuana user. Even within individual drug categories one will find different classes of users. Thus, the marihuana user may be a very "hip" looking long-haired, radically dressed youth; or, he may be a very "straight" looking, carefully manicured, conservatively-dressed business man. The same can be said of abusers of other drugs, such as barbiturates and amphetamines, which cut across age, race, economic and cultural lines.

One important method of classifying the drug user's life style is to determine whether he has "dropped out" of a productive role in society. Many abusers will continue to function until drugs have "captured them" to the point where their behavior would be considered abnormal by a drug-free person. Examples would in-

clude the LSD victim who has become psychotic or who cannot control his hallucinations, or the "speed freak" whose emotional stability has been shattered. A second reason for dropping out can be seen in the case of the heroin addict who must turn to crime in order to support his habit. A third class makes a decision to reject society independent of the influences of the drug and the need for fast money to support their habits. This group intentionally joins a drug-oriented culture as a form of "protest" or as a way of searching for a "better life."

Many individuals, having once shed their clothing, rarely left the idyllic state of nudity pictured above.

This final group is, perhaps, the most interesting. Very frequently their life styles represent an utter rejection of all things attributable to the "establishment."

Traditional clothing, hairstyles, and hygiene are dismissed as being "middle class" (in the pejorative sense). Continuing gainful employment is rejected as a "sell out" to the "straight life." For this reason, members of the youthful drug culture will work only when necessary. Even then the jobs selected are of a menial, semi-skilled and unskilled nature. Few, if any, qualms exist against "ripping off" (stealing) the property of straight members of a society. They are regarded as "capitalist pigs" — the assumption being that as such they acquired their possessions in an illegitimate fashion at the expense of the poor and laboring classes. Thus, in the subculturists view, the property is not really stolen—it is simply "liberated."

In the majority of instances, members of youthful drug subcultures are oriented to radical leftist politics. This is in keeping with their rejection of all things connected with their parents. A host of causes are typically espoused such as ending the draft, legalizing all drugs and freeing "political prisoners" such as Fathers Daniel and Philip Berrigan and Angela Davis.

Unprecedented levels of sexual freedom are also practiced by members of many drug-oriented subcultures. In several areas of the United States the phenomenon of group sex has closely paralleled growing levels of drug abuse. It has also played a major part in causing the epidemic proportions of venereal disease currently being experienced in this country.

The above practices and characteristics are best exemplified in America's proliferating drug communes. These are to be distinguished from the many communes which are strictly opposed to drug use. These latter groups have returned to the soil for their existence. They maintain stringent, almost puritanical standards of behavior and, in many cases, have proven to be unusually industrious. They are, in fact, the polar opposite of the drug communes. This is not to say, however, that there is no middle ground. There are many communes which are quite moralistic and extremely industrious but which, nevertheless, espouse limited drug useage.

Not all communes are of the agrarian variety. Many are located in the cities. The central concept is that of sharing everything with one's fellow members. In the case of the drug commune this includes drugs, clothing, food, sex, and anything else that is brought into the group. Frequently, a large bowl or receptacle will be provided for members' drug contributions. Quantities of pills of all colors and descriptions will be tossed into the potpourri. This conglomeration of hallucinogens, stimulants, and depressants is known in the drug world as "fruit salad." When the drug abuser wishes to leave the world of reality, he simply chooses the tablets he desires or swallows a random handful on a potluck basis. The hazards of this latter form of russian roulette are too obvious to mention.

In the main, however, most youthful drug users lead conventional lives. Most young people who use drugs do not orient their entire life style around drugs. For the most part, the majority of the youthful drug culture uses drugs in moderation — usually for purposes far removed from those suggested by Leary and his followers.

According to a recent poll, there are however, strong indications that "the drug culture that began to grown on the campus in the sixties, is now a heavy part of the life style practiced by most of America's students." According to a poll published in the September issue of *Playboy* magazine:

> The majority of American students use alcohol and grass for their highs, but a large number of them are also into amphetamines and barbiturates, mescaline and LSD, and a growing number are experimenting with hard drugs—cocaine and heroin.

The study showed that alcohol remains the most popular "drug" on campus. Most college students (94 per cent) have tried alcohol, and 80 per cent report regular use.

Marihuana, however, is waging a strong challenge. Approximately 62 per cent of all college students have tried pot. This represents a startling increase of 15 per cent over the year before. The percentage of use goes up in direct relation to a student's age. Of the 17-year-olds, 56 per cent reported they are users. The figure increases to 67 per cent for 22-year-olds. Despite the great increase in marihuana use the report notes that 21 per cent of the users said that they did not plan to use cannabis again in the near future.

The use of other drugs has remained comparatively small although all categories show increases. Amphetamine use is up 12 per cent. Today 30 per cent of the students have used speed drugs — generally to stay awake for long periods of study. However, almost half (42 per cent) said they did not intend to take the drug again.

The 22 per cent who reported use of barbiturates is up by seven per cent over last year's reported use. Women reported use in exactly the same over-all percentage that men did and slightly higher for frequent use. This is the only drug in which female use does not trail male use by a significant margin. Almost half (48 per cent) of the students who used barbiturates said they intended to stop.

Nearly one fifth (18 per cent) have tried mescaline (or what they thought to be mescaline). Over one third (38 per cent) of the users said they intended to stay away from it in the future.

Use of LSD is up only 2 per cent over last year for a total percentage of 13 per cent. This probably reflects continued reports of its possible harmful effects. Over half (52 per cent) of those who use it say they will stop.

National statistics on the use of cocaine indicate that this once nearly forgotten drug is enjoying a comeback. Of the 7 per cent use reported by the survey, 4 per cent said they had used cocaine 1 to 3 times, 1 per cent said 4 to 9 times and 2 per cent said they had used it 10 times or more. Only 27 per cent of the users said they intended to stay away from the drug in the future.

Despite the epidemic use of heroin on the streets and by soldiers in Vietnam, the campus statistics for this drug show only a slight increase, if any. Fewer than 1 per cent of the total admitted being addicted to the drug. Of the users, 45 per cent said they will stop.

International Perspective

The youthful drug culture is by no means confined to the United States. Other countries are beginning to experience rising rates of drug abuse among the young. Virtually all European countries have reported increases in recent years. Large metropolitan centers such as London, Paris and Rome have drawn thousands of young drug abusers to the various "Bohemian" sections of those cities. In Amsterdam, large "hippie-type" communes have been designated in several of the city's public parks. Reportedly, law enforcement authorities have maintained a "hands-off" policy even though drug abuse among the commune members is rife.

The most popular gathering place is in the Liedesplein district of Amsterdam with its hashish dens and huge Vondel Park where, unlike most American urban parks, authorities have allowed camping. Vondel Park is a maze of multicolored tents. The government has opened a pavilion for luggage storage and food is available at prices far below those in the city.

Police maintain patrols in the park but are generally quite hospitable to the campers. The scene today, is much different from the Amsterdam of 10 years ago when there were frequent bloody clashes between young people and the police.

Each night thousands of youths flock to the "Melk Weg" (the Milky Way), an abandoned warehouse, where they watch silent movies, listen to rock music and smoke hashish. Though drugs are technically illegal, the police do not go near the Melk Weg. Dozens of hawkers walk about the entrances selling hashish, LSD and almost any other drug, including heroin, at prices of less than one fourth what they are in the United States.

Amsterdam is by no means a paradise, however. Many tourists have returned to America speaking contemptuously of the large numbers of youths who have dropped out of the mainstream of society. They tell of youths who have entered a totally drug-oriented milieu. Those who have given up the "straight life" remain "stoned" on drugs almost constantly. When lucidity returns, their first impulse is to flee from reality into the welcoming arms of drug dependence.

Many of the residents in the foreign cities who comprise the drug cultures are American youths. Frequently they have severed all ties with their homes and have run out of money. As is the case in America they must turn to crime if they are to support their drug habits.

In some instances they have been relegated to begging. A recent report from Afghanistan indicates that young American and British hippies are "begging like dogs" for drugs in the streets. Afghanistan has become the center of world trade in hashish.

The report was issued by Peter Willey, who visited the Central Asian country on behalf of the British Antislavery Society. Willey said that the hippies make the "pilgrimage" to Afghanistan because some of the country's religious have a tradition of drug taking. Moreover, they know that drug supplies are plentiful there, while their money holds out.

According to the report, "These young men sell their possessions, their bodies, and those of their girl friends to buy their hashish." Willey told of seeing hippies in "sun-drenched squares that reek of death and decay." Others, he said, live in "sordid tawdry lodging houses." He added that often they are desperately ill with hepatitis and malnutrition.

The report went on to note that, "They have become dependent on scraps of food, contemptuous of charity and a daily supply of hashish or other narcotics provided often by the Afghans who treat them as weird human pets."

Chapter 4
MARIHUANA

Introduction

According to the Commission on Narcotic Drugs of the Economic and Social Council of the United Nations, marihuana abuse is more widespread, from a geographical standpoint, than abuse of any other dangerous drug. Widely encountered in North and South America, Africa, Southeast Asia and the Middle East, it is known as bhang or ganja in India, hashish in the Middle East, dagga is South Africa and maconha or djamba in South America. Although the potency and methods of production may differ from one area to another, the pharmacologically active ingredient is identical in all forms.

This intoxicating substance (tetrahydrocannabinol or THC) which gives marihuana its activity is found primarily in a resin from the flowering tops and leaves of the female Indian hemp plant, *Cannabis sativa L.* The potency of marihuana varies with the geographical location in which the plant grows, time of harvest, and the plant parts used. Other determining factors may include the methods used in cultivation, how it is prepared for use and how it is stored. For example, the marihuana grown locally in Illinois is much weaker and far less popular than that grown in Mexico. Moreover, the marihuana cigarette or "joint" is much less potent than hashish since the latter contains more resin.

Marihuana is made by crushing or chopping into small pieces the dried leaves and flowers of the plant. This green product is usually rolled and smoked in short cigarettes or pipes, or it can be eaten mixed with food. The cigarettes are commonly known as "joints," "reefers," or "sticks." The small nubbin or butt of the cigarette containing the last few puffs is known as a "roach." The roach is highly prized among marihuana smokers since it contains the greatest residuum of THC and therefore produces the greatest high. The smoke from marihuana is harsh and smells like burnt rope or dried hay. Its sweetish odor is easily recognized.

Next to marihuana the type of cannabis most frequently used in the United States illicit traffic is hashish that is smuggled into this country from Syria, Lebanon, Afghanistan, and Middle East and North Africa countries. Hashish is made by a relatively simple process. Branches of the mature plant are repeatedly hit against a flat surface, usually a table or flat board. The resin from the leaves adheres to the table or board in the form of fine powder which is then scraped up with a knife. The powder is then inserted into the open end of an inverted, hand-sewn, cotton cloth sack about 4 inches wide, 7 inches long and ½ inch deep. When full, the open end is hand-stitched closed. A hot steam iron is applied to both sides of the sack, compressing the powder into a cohesive mass, and the sack takes the shape of a flat, brick slab. The heat application, and exposure of the porous cloth sack to the air, change the color of the substance from grass-green to a dark green-brown, almost the shade of common chewing tobacco.

Pieces, the size of small fingernails, are easily chipped off the slabe by hand or with a knife. They are crumbled, mixed in with ordinary cigarette tobacco, rolled into cigarette paper, and smoked like marihuana. In the United States, hashish is also smoked in hookah water pipes, emulating the practice long employed in Arabic countries.

Hashish is obviously more potent than marihuana because it is concentrated resin; whereas a marihuana cigarette contains a mixture of resin and portions of inactive plant ingredients.

History

Although it has been known to man for nearly 5,000 years, marihuana is one of the least understood of all natural drugs. Its fibers have been used to manufacture twine, rope, bags, clothing, and paper. The sterilized seeds are occasionally used in various feed mixtures, particularly for bird seed.

The use of marihuana dates back in antiquity. Primitive people used it to induce states of intoxication during religious rites or, in the case of hashish, to prepare warriors for battle. Some authorities have suggested that our word "assassin" derives from hashish. Hashish was used by the soldiers of the Arabian leader Hasan-Ibn-Sabbah who died in 1124 A.D. Before going into battle or before stealing into an enemy's camp, Hasan's men would frequently smoke hashish.

Medical uses for marihuana were prescribed as far back as 2737 B.C. when the Chinese emperor Shen Neng discussed the drug in a book on pharmacology known as the *Per Ts'ao*. He recommended cannabis in treating gout, constipation and "absent-mindedness," among other uses. The plant is described with amazing botanical insight in a 5th century B.C. Chinese treatise entitled *Rh-Ya*. The work noted that hemp grow in both male and female forms. The former producing seeds and the latter flowers.

For several hundred years hemp remained the principal source of cloth for the Chinese. For some reason they failed to recognize the advantages of using flax fiber.

Although the Chinese used hemp for clothing, and later for medical purposes, they apparently never smoked it or appreciated its euphoric properties.

Unlike the Chinese, the Hindus of India cultivated marihuana for its resin which they used in religious ceremonies for its intoxicating qualities. The use of cannabis soon became inextricably entwined with Indian philosophy and religion. Some of the earliest native literature extols the psychotoxic effects of the plant.

In 500 B.C., the Scythians were reported by the Greek author Herodotus to be using the drug. He wrote that the Scythians were in the practice of throwing marihuana seeds on red-hot stones in an enclosed space. They would then wait to be transported by the vapors produced by the burning cannabis.

Soon the drug had spread throughout Europe and Africa. By 500 A.D., cannabis had been cultivated in nearly all of Europe. It was already well known in the New World at the time of Columbus.

The use of marihuana in the treatment of illness has generally been confined to Asian countries. It is still encountered in India and Pakistan as a local remedy. In the United States it was once used as an analgesic and a poultice for corns and enjoyed some medical respectability during the 19th century. Today it no longer has any acceptable medical use in this country. Its disappearance as a medicine in western civilization was due primarily to the safety and effectiveness of the newer drugs which far outweighed the limited utility, if any, of marihuana.

Cannabis was not widely experienced as a euphoriant in western civilization until the mid 19th century. In 1844, the French writer Theo-

phile Gautier founded the notorious Club des Haschischins at the Hotel Pimodan in Paris. The club delicacy was a sweetmeat, Dawamese, which contained hashish. Other French authors such as Alexandre Dumas and Charles Baudelaire also experienced and wrote about marihuana.

Hemp was cultivated in America for use in making rope to be used aboard Britain's shipping fleet. Unlike flax, cannabis provided long, flexible, strong fibers which were excellent in preparing heavy ropes for sea duty. Thus, as early as 1611, cannabis was harvested near Jamestown, Virginia. By 1630 hemp had become an important item in the colonial economy —both as a source of income and a basic fiber used in making clothing.

Cannabis received very little notoriety in the United States until very recently. It did not receive the critical acclaim among the literati that it enjoyed in France. Few exhibited the infatuation of Gautier. One notable exception, however, was Fit Hugh Ludlow, who, in 1860, anonymously published *The Hashish Eater.*

This marihuana leaf measures 9½ inches long.

Cannabis was the source of considerable debate among the medical profession during the 19th century. Gautier and his intellectual friends at the Club des Haschischins conducted many self-experiments with marihuana. By the close of the Century however, most scientists agreed that it was almost impossible to prepare a standardized extract from cannabis.

Nevertheless, many patent medicine promoters marketed a number of marihuana concoctions. The East India Consumption Cure was made up entirely of *Cannabis sativa.* It was promoted during the late 19th century as:

> . . . a reliable remedy and certain cure. It secures Refreshing Sleep, and puts an immediate stop to the annoying and debilitating night sweats, makes the Head Clear, and the spirits free and hopeful, the mind active and undisturbed. In fact, it cures all cases of Consumption, Bronchitis, Asthma, Catarrh, Nervous Debility and all Nervous Complaints which have not progressed beyond the reach of curative agents.

It was prepared according to the original formula of W. C. Stevens, M.D., and marketed by W. A. Noyes of Rochester, New York. In this present era of saturation advertisting by pharmaceutical manufacturing companies and sophisticated ad agencies, one wonders what sort of approaches would be used if marihuana were suddenly legalized. Undoubtedly, a massive market would be created overnight with such grand promises of health and happiness.

Scientific research continued into the biochemistry and pharmacology of cannabis. The findings, however, were invariably inconclusive because of the complexity of cannabis. Because of this uncertainty cannabis ceased to be used for medical purposes. It has lately, however, enjoyed something of a rebirth. A recent *Newsweek* article on marihuana reported that a Beverly Hills matron suffering from nervous tension was prescribed cannabis by her family doctor to relieve her symptoms.

Traffic in and use of cannabis is now legally restricted in nearly every civilized country of the world. This includes countries where marihuana is used in religious ceremonies or as a native medicine.

The non-medical use of marihuana in America is of relatively recent origin. Introduced into the southern states by Mexican laborers, the

habit of smoking marihuana probably first took hold in New Orleans. Soon it was estimated that thousands of pounds of the weed were smuggled into the United States. The use spread throughout the country to virtually every major city. Lurid stories began to appear in the daily press concerning the effects of the drug. A variety of instances were reported where drugged individuals were said to have lost control of their actions and committed unpremeditated acts of violence.

One of the prime movers and most forceful anti-marihuana crusaders was Earle Albert Towell, whose book entitled *The Weed of Madness* effectively stirred popular sentiment against the drug. Towell's campaign was supplemented by the zealous efforts of Harry J. Anslinger, the Commissioner of the Bureau of Narcotics.

The fight to outlaw marihuana was won on August 2, 1937, when President Franklin D. Roosevelt signed into law The Marihuana Tax Act which placed cannabis in the same class as narcotics and cocaine. The Act placed marihuana under federal control through taxing power. It required all persons who sold, imported, produced or distributed marihuana in any way to register and pay a graduated occupational tax. In 1969 the Supreme Court held that the Marihuana Tax Act is unenforceable when the accused claims his Fifth Amendment privilege against self-incrimination. The Court also declared unreasonable the law's presumption that a person with marihuana in his possession knows that it was imported illegally, thus violating due process of law.

Even at the time of the passage of the Marihuana Tax Act authorities did not agree on the extent of the dangers of marihuana. For example, the *Military Surgeon Journal* in 1943 editorialized that, "The smoking of the leaves, flowers and seeds of Cannabis sativa is no more harmful than the smoking of tobacco or mullein or sumac leaves . . . hence the legislation in relation to marihuana is ill advised . . ."

In an effort to assess the true hazards of marihuana use, Mayor LaGuardia empowered a special committee to study the matter in New York City. Its 1944 report stated that marihuana generally was used in the form of cigarettes commonly called "muggle" or "reefers."

Most of the smoking in New York City was found to be taking place in Harlem, where there were about 500 "teapads." These were generally comfortably furnished rooms with a radio, phonograph or juke-box. The lighting was usually dim with blue predominating. An incense burner was considered a natural part of the furnishings.

The Report went on to describe typical marihuana parties of the time at which there was reported a very congenial atmosphere and a great willingness to share and puff each other's cigarettes. The Report also concluded that marihuana was not addicting, that its use bore no significant relationship to crime and delinquency and that there was no evidence that its use was the first step toward using narcotics. Finally, the committee found that "the publicity concerning the catasrophic effects of marihuana smoking in New York City is unfounded" and that "marihuana was a minor nuisance rather than a major menace."

These conclusions were reported in *Down Beat* magazine with the headline "Light Up Gates, Report Finds Tea a Good Kick." Since marihuana was exceedingly popular among jazz musicians, this report was well received. The LaGuardia Report, in fact, to this day is of considerable significance in the history of jazz's development in the United States.

It may be noted here that jazz musicians were among the earliest experimenters with marihuana. Its heavy use continues today among members of this profession and other music forms which are heavily rhythm oriented. There are, however, many musicians who have come to reject marihuana. In testimony before Representative Claude Pepper's Select Committee on Crime, the famed jazz drummer, Gene Krupa, said that he has not only watched the drug's influence in the music field but that he has been a part of it. Krupa, one of the greatest names in the history of jazz, nearly came to the end of his career a number of years ago because of his involvement with drugs. At the time the public was far less understanding toward drug dependency than it is today. Krupa told the Committee:

> To a drummer, time is his reason for being. He provides the tempo for his band. I thought I could do a better job with drugs, but they fooled me. When I listened to my drums afterward, the recording showed me that my music wasn't what I thought it was.
>
> I'm not alone either. I think most good musicians who have experimented with drugs have had the same conclusions: fine performance comes from the expression of talent, and if a man doesn't have the talent he can not perform well. At the same time, if he has the talent he only muddies it up by using drugs. That reasoning caused me to quit,

A police officer examines wild marihuana.

and I advised other to quit. In music or other fields, drugs cannot help.

The LaGuardia Report drew severe criticism from several fronts. The American Medical Association blasted the report for drawing sweeping and unscientific conclusions which minimized the harmlessness of marihuana. To quote the *AMA Journal:*

> The book states unqualifiedly to the public that the use of this narcotic does not lead to physical, mental, or moral degeneration and that permanent deleterious effects from its continued use were not observed on 77 prisoners. This statement has already done great damage to the cause of law enforcement. Public officials will do well to disregard this unscientific, uncritical study and continue to regard marihuana as a menace wherever it is purveyed.

Mayor LaGuardia retorted, "The findings were to be interpreted only as a reassuring report of progress and not as encouragement of indulgence." He assured the AMA and the public that he clearly intended to enforce the law against the use of marihuana.

The controversy following the 1944 New York Report was only the beginning.

For all intents and purposes, marihuana had been dropped from medical practice. The remaining debate, therefore, was now confined to the degree of penalty to be dealt to marihuana users. The President's Advisory Commission on Narcotics and Drug Abuse in 1963 recognized "the relatively trivial nature of the marihuana evil" by suggesting all mandatory sentences be eliminated from crimes involving it alone. Many have now proposed that the law ought to deal with the marihuana user along the same lines that are used with persons who drink alcohol. That is, the *intoxication* rather than the drug itself, is what should be the concern of the law. This group would, therefore, favor total legalization of marihuana. There are others at the other end of the continuum who still abide by the early views concerning marihuana voiced by crusaders of former times such as Earle Albert Towell. As indicated in Chapter 2, this Commission has rejected both extremes in drafting legislation. We recognized the relatively mild effects of marihuana but remained concerned about its potential hazards and the consequences of introducing on a large scale another euphoriant into an already drug dependent society.

In England, use of marihuana increased to such an extent that another survey was conducted. The results were published by the British Standing Advisory Committee on Drug Dependence. The report is known as the Wootton Report after the chairman, Baroness Wootton. The 1968 British Report, like the 1944 New York report, concluded that "there is no evidence that cannabis is causing violent crime or aggressive anti-social behavior; in spite of the severe penalties and considerable effort in enforcement, the use of cannabis in the United Kingdom is increasing. New legislation dealing separately with cannabis is needed, and it is necessary to maintain restrictions on the availability and use of the drug."

The psychoactive constituents of cannabis were isolated in 1940, and tetrahydrocannabinol (THC), the major active euphoric ingredient of cannabis, was first synthesized by a research team at Hebrew University in Israel. This was a tremendous breakthrough in providing the means of establishing a better understanding of marihuana through controlled scientific research into its effects.

Scientists have since found that there are a variety of isomers (chemical variations) of THC, some of which are as much as 10 to 15 times as potent as psychoactive agents as other isomers. They have also recognized the instability of THC which perplexed the 19th century scientists in trying to obtain standardized extracts. As is the case with much scientific research the use of cannabis had to assume near epidemic proportions before a mobilization of efforts could take place. The same can be said for the efforts of the health professions, educators, the public, and, of course, the legislators.

Botanical Classification

All marihuana comes from the plant botanically classified as *Cannabis sativa L.* It was first named by Linnaeus in 1793. The name *cannabis* is Latin for "hemp," or canelike plant. It denotes the genus of the hemp family of plants. *Sativa,* the species name, is Latin for "planted or sown." This denotes the fact that the plant grows from seeds, not from perennial roots.

Cannabis is a unique plant. It exists in a single species although there are a number of varieties. The three most common varieties are *Cannabis indica, Cannabis americana,* and *Cannabis mexicana.* These botanical names indicate the difference among the varieties which occurs as they grow in various geographical regions of the world. The varieties differ from each other in the quantity and potency of the resin they produce. The geographical location of the individual plant will largely determine the amount and potency of the resin. *Cannabis indica,* for instance, contains the most powerful resin of all the varieties. This resin, which is commonly referred to as hashish, is more than five times more intoxicating than the resins of *Cannabis americana* or *Cannabis mexicana.*

The plant grows in mild climates throughout the world, especially Mexico, Africa, India, and the Middle East. It also grows in the United States, particularly in the midwest and south where the term "marihuana" and all of its vernacular synonyms are applied to the various parts of, or preparations of, the cannabis plant, excluding the stalks and sterilized seeds. Although the plant grows wild in most areas, it can easily be cultivated and harvested as a crop.

Cannabis has a long history of commercial usefulness. In addition to the uses of the plant in manufacturing rope, clothing, certain papers, and other items it is also a commercial source of an oil which is an ingredient of various paints, varnishes, and linoleum.

Cannabis is technically classified as a herbaceous annual. This term describes it as a leafy plant with little or no woody parts which grows for a season, dies, and then springs up again the following year from its own seed.

Cannabis is also classified as dioecious: it requires both a male and female plant in order to reproduce itself. Both sexes have flowering tops and both produce resin with psychotoxic properties. The male, however, produces very little useful resin compared to the female and is virtually useless as a source of marihuana. In fact, a common premise in cultivating marihuana is the removal of all male plants after fertilization of the female varieties has taken place. Recently, however, a hermaphroditic variety of cannabis has been produced. Initial research has shown that both the predominantly male and female sexes of this new variety produce equally copious and potent resin.

The male variety is taller than the female and not as darkly hued. The fibers found in the stem of the male plant yield the hemp. The female constitutes the shorter darker plant.

At the time of fertilization the male plant produces flowers which open wide to expose pollen-laden stamens. The female plant also blossoms at this time. The female's flower contains a pistil, or egg-bearing sprig which awaits the arrival of the pollen. Since insects meticulously avoid contact with cannabis, the female plant must depend upon a properly directed breeze to bring the pollen to her. Once the wind has pollenized the female, reproduction begins, mature seeds form and fall to the ground thereby renewing the cycle of life. After it has served its reproductive purpose, the male plant dies. As noted previously, when cultivated for commercial harvest the male plant is usually pulled out by the roots after pollination has occurred.

The ordinary life span for cannabis usually runs from spring to fall. At the height of the

season the female flowers cluster. The top of the plant exudes a sticky golden yellow resin. The stickier the resin the greater the intoxication potential. Cannabis has a distinctive odor which, as might be expected, smells like freshly made hemp rope. The resin, however, frequently exhibits a faint mint-like odor. Although the resin is initially yellow, cumulative exposure to the sun ultimately turns it into a green-black color.

Harvesting of the cannabis plant is aimed principally at the gathering of its resinous flowering tops. The cannabis which grows in hot dry climates such as North Africa and the Middle East will produce tremendous quantities of resin. Obviously the harvesters of a marihuana crop take all possible steps to assure that none of the resin will go unreaped. In India, cannabis specialists known as "Ganja" (marihuana) doctors travel up and down the commercial fields trimming the lower branches of the female plants to encourage increased resin production. In Nepal it is reported that nude men were once used to harvest the cannabis resin. At harvest time they would scurry down the long roads of cannabis plants and make every effort to cause the resin to adhere to their bodies. At the conclusion of their marathon the sticky substance would be scraped from their bodies.

Cannabis is an unusual looking plant. Its stalk is hollow, leafy and four-cornered. In some climates it can grow as high as 20 feet. In most regions, however, including the Midwestern United States marihuana rarely grows higher than seven feet and is usually much shorter than that. If not crowded by other plants, cannabis will bush out with many branches. Full grown cannabis cultivated in hot regions may produce stalks which are three to four inches thick. Again, in milder climates stalks more than an inch or two in width are rare. Four ridges run lengthwise up the stalk with well marked nodes or knots every few inches. The plant exhibits very distinctive leaves. These are compound and consist of a number of smaller leaflets. These smaller leaflets or lobules, as they are called, are uniform in number, with five to eleven being present in a single leaf. The two outer leaflets are always smaller than the rest of the grouping. The sides of the leaflet are serrated with pronounced ridges running diagonally from their center to the edges. The upper side of the leaflet is dark green with the underside being a lighter shade. Long hairs run along the bottom of the leaflets. Cannabis flowers appear as an irregular cluster of light yellowish-green shades.

The manufacture of marihuana from the hemp plant begins with the harvesting of the resin from the tops of the female plants. All forms of marihuana as they are found in numerous locations in the world are basically variations in form of the harvested resin.

Derivation

These resin-laden cannabis leaves have generated an international vocabulary for the various forms of cannabis. Most of the terms are synonymous with cannabis. The term "marihuana" is of uncertain origin. It may have arisen from the Mexican-Spanish *mariguana* or the Portugese *mariguango*. Both of these words mean "intoxicant." In its present form, *marihuana* or *marijuana*, it is Mexican-Spanish for the girl's name "Mary Jane" or *Maria Y Juana* which means "Mary and Jane." Dr. Edward Bloomquist in his book *Marijuana* suggests that it may have come from an even earlier source. He notes that the Aztec word for cannabis was *Milan-a-Huan* which the early Spanish conquerors cound not pronounce and so enunciated *maria-juana*.

In the United States and in other English speaking countries the term "marihuana" or "marijuana" usually refers to the preparation made from the flowering tops of the cannabis plant containing the unextracted resin. This usually appears as a dried chopped green plant substance. In better grades of marihuana the stalks and seeds have been removed in a process known as "manicuring." The many street terms for marihuana such as "pot" and "grass" merely represent synonymous terms for the marihuana itself. Geographical references such as Acapulco Gold or Panama Red are references to its place of origin.

The Indians refer to cannabis as *charas, bhang,* or *ganja*. A smoking mixture which contains the harvested tops of the uncultivated female *Cannabis indica* plant is known as *bhang*. It has a low resin content and is therefore not very potent. In terms of preparation and appearance it is most comparable to marihuana. *Ganja* represents a more potent form of *bhang*. It usually consists of the resinous cut tops of a specifically harvested grade of *Cannabis indica*. *Charas* and *hashish* are extremely powerful preparations made from the same *Cannabis indica* plants used in preparing *ganja*. *Charas* differs from *ganja* in that it consists of pure, unadulterated resin obtained from the special *ganja* plants.

India is not alone in its varied references to

marihuana. Virtually every country in which the drug has made an appearance has given it one or more names. A partial list appears below:

India	—charas, charras, churrus, bhang, blang, ganja
Middle East	—kif, keif, hashish, el kif, takouri, shira, banj, setol
East Africa	—moto kwane, hjemu, njaga
South Africa	—djamba, liamba, riamba, heigum, haium, ssruma, kaal, dumo
West Africa	—yamba, diamba
Central Africa	—mbanzha, mbangi, mata kwane, snstangu, dagga
Malagasy	—vongony, rongony
China	—ma-yo
Russia	—anascha
Spain	—canamo, noto
France	—l'herbe, chanvre
Brazil	—machoma, maconha, ciemba, liamba, diamba
Central America	—yerba, yerba Santa
Mexico	—mota, moto, mo-tul, manteca, las tres, marijuana

Thus, each country seems to have its preferred terminology in referring to the plant. A listing of the many terms used in describing cannabis preparations can be found in the glossary at the end of this Report. Except when otherwise indicated, the term "marihuana" as it appears in these pages refers to the cannabis most commonly found in the United States, specifically, chopped preparations of the flowering tops of the female hemp plant.

Pharmacology

Marihuana is not a narcotic even though it is so classified by many states. As a drug it is

State police officers destroy catches of packaged marihuana.

unique: it is not a stimulant, not a sedative, not a tranquilizer, not a narcotic, and not a hallucinogen — although it shares some properties with all of these. Perhaps "euphoriant" might be a proper classification. But even this word does not fully suggest the temporary changes in perception of time, of humor, of sense experiences such as eating and sex and listening to music, that most smokers report.

In any case, there is no evidence that marihuana leads to addiction no matter how often it is smoked (although a psychological dependence may be developed).

This is not to suggest that the habituation found among chronic marihuana users should be deemphasized. Psychological dependence is a very real element of marihuana's drug abuse pattern. Pharmacologically speaking, cannabis does not cause addiction in the proper sense of the word since the term addiction contemplates psychological dependence, tolerance, and physical dependence with the appearance of withdrawal symptoms if the drug is abruptly withdrawn from a chronic user with a substantial daily dosage rate. In all of the requirements used in finding an addictive drug the most important consideration is psychological dependence. It is well known, for example, that even among true narcotic addicts the psychological dependence is far more powerful than the physical dependence.

The problem of classifying drugs according to whether they are addictive has been a major problem since it frequently clouds the issue of whether or not a given drug is dangerous and requires control. A solution to this semantic problem has been offered by the World Health Organization. In 1964 that organization's Expert Committee on Addiction-producing Drugs suggested that a new nomenclature be devised which would better describe and categorize drugs. The organization suggested that the terms "addiction" and "habituation" be replaced by the term "drug dependence" with accompanying features being considered a part of the total abuse syndrome associated with a given drug. This would facilitate discussion of their dependence patterns. Thus, instead of dismissing marihuana as a non-addictive drug and then qualifying this statement with a lengthy experimentation of psychological dependence, it may be more appropriate to refer at the outset to a *cannabis dependendence syndrome.* The same would, of course, apply to dependence syndromes identified with other drugs such as heroin, nicotine or alcohol. Persons who use marihuana continually as a symptomatic expression of a psychological conflict, a means of gaining social acceptance, or a way of escaping painful experiences of anxiety or depression may be said to be psychologically dependent on the substance. Continuous use may be associated with the development of psychic illness, although few chronic users are ever admitted to psychiatric in-patient facilities.

Chronic marihuana users often are lethargic, neglect their personal appearance, and occasionally may experience a deep sense of failure after believing they are capable of accomplishing great things. The extent of psychological dependence on marihuana in the United States is not known, but such dependence may be reasonably presumed to be less than that to narcotics, stimulants, and depressants. This belief is based on the ground that the satisfactions obtained from marihuana by drug dependence-prone individuals are insufficient to meet their psychological needs.

The actions of cannabis are exerted primarily on the central nervous system, but its modes of action are poorly understood. The effects of marihuana, through smoking, are felt in a very few minutes and may persist for as long as 12 hours. Moreover, the chronic user does not require ever increasing amounts to get high. To the contrary, veteran smokers often require less than novices.

In this regard a United States Public Health Service Research team recently announced that marihuana smokers may become more and more sensitive, psychologically and physically, to the drug as its by-products build up in bodily tissues. They said that THC lingered in the blood stream for more than three days and by-products persisted for eight. This may indicate that marihuana residues build up in bodily tissues such as those found in the lungs and the brain. The body's retention of THC and its by-products may explain the reverse tolerance phenomenon, in which marihuana smokers appear to experience more intense reactions to the drug with each additional dose.

At this juncture surprisingly little is known about the pharmacology of cannabis. The basic reason for this paucity of knowledge is the extreme chemical complexity of the psychoactive ingredients of the drug. Research was slow to begin because marihuana was not regarded as a major national problem until recent years. Moreover, since the plant itself was strictly controlled by law, research samples were difficult to obtain.

Merely to obtain marihuana legally for ex-

perimental purposes was a serious obstacle for many years. Today this has become less of a problem since governmental licensing of cannabis cultivation and use in connection with scientific research is now a reality. The National Institute of Mental Health, for instance, now grows its own on a well-guarded 20 acre plot in Mississippi. But the problem of insuring that the cannabis used in a test is of uniform potency remains. To get around this difficulty many experiments are now conducted not with marihuana but with tetrahydrocannabinol (Delta-9-THC or Delta-1-THC). But no one is quite sure that THC is the only active ingredient in marihuana: a THC high may differ from a normal pot high.

Effects of Cannabis Use

Early warnings against the "killer weed" made mention of the criminal instincts and sexual depravity that the drug reportedly released. These perils have now been largely discredited. Cannabis usually prompts relaxation and even passivity as the most common reactions.

Although some users feel that their sexual interest and pleasure are enhanced, recent research has shown that heavy, prolonged use of marihuana may produce impotency in certain chronic users. The exact reason for this impotency, however, is difficult to determine. It may be that the life style of a chronic marihuana user contains a good deal more erotic sexual episodes during the early years of cannabis use. It is arguable that the impotency displayed by chronic male marihuana smokers in their mid 30's is the jaded result of years of a saturation program of erotica. Dr. Bloomquist has suggested that this impotency is probably only psychological. The continuous exposure to highly arousing and unconventional encounters may produce a reliance or "dependency" on unusually high sexual expectations. Having taken up the crutch of marihuana, and having experienced only the most erotic episodes, sexual encounters which do not involve marihuana nor advanced degrees of sexuality, do not appeal to the chronic user's libido. Hence, he is unable to perform sexually.

Evidence of female "impotency" or frigidity has not been as well established. In a recent study published in the *Journal of the American Medical Association* Doctors Harold Kolansky and William T. Moore reported an unusual degree of sexual promiscuity among adolescents and young adult users of marihuana that they have studied between 1965 and 1970. Most of the 38 patients in this study smoked marihuana two or more times weekly and, in general, smoked two or more marihuana cigarettes each time. Thirteen female individuals, all unmarried and ranging in age from 13 to 22 were studied by Kolansky and Moore. They reported that:

> This group is singled out because of the unusual degree of sexual promiscuity, which ranged from sexual relations with several individuals of the opposite sex to relations with individuals of the same sex, individuals of both sexes and sometimes, individuals of both sexes on the same evening.

The researchers reported that they were struck by the loss of sexual inhibitions after short periods of marihuana smoking. They report that seven patients of this group became pregnant and four developed veneral diseases. Five of the 13 were engaged in homosexual activities which began after the onset of smoking and three attempted suicide.

They concluded by noting that:

> In no instance was there sexual promiscuity prior to the beginning of marihuana smoking, and in only two of the thirteen cases were there histories of mild anxiety states prior to smoking. We take these results to indicate marihuana's effect on loosening the self-ego controls and altering self-ego ideals.

It should be noted that this study was recently criticized in testimony before the National Commission on Marijuana and Drug Abuse. The critics objected mainly to the drawing of conclusions from an uncontrolled non-laboratory study in which the 38 subjects observed were all persons who had been referred to Doctors Kolansky or Moore as having mental problems. Doctor Norman E. Zinberg of the Harvard Medical School, and author of numerous scientific articles on marihuana, did not see how the two Philadelphia psychoanalysts had proved any cause-and-effect relationship. To him, most of the symptoms that Kolansky and Moore mentioned sounded rather typical for American teenagers — particularly the kind who are referred to analysts.

Other psychiatrists questioned the assumption by Kolansky and Moore that the patients had been "normal" before their use of marihuana began, since the doctors had based this conclusion of prior normality only on what the patients themselves or their parents had said.

Kolansky and Moore freely admitted that their study was an uncontrolled set of clinical observations rather than a laboratory experiment,

Perhaps the best known usage item of marihuana smokers is the famous "Mr. Zig-Zag" package of cigarette rolling papers.

comparing users with a parallel group of non-users. However, the doctors said, "for the practicing physician the clinical setting is his laboratory . . ." In addition to sexual promiscuity, their study indicated that pot-using adolescents exhibit such symptoms of "psychopathic" trouble as distraction, inarticulateness, short attention span, and poor coordination.

There appears to be some impairment of the ability to perform complex tasks while high on marihuana. Research on driving skills, however, is not yet conclusive. One study commissioned by the State of Washington indicated that drivers high on a normal dose of marihuana committed no more errors than they did while free from the effects of cannabis, whereas their scores were notably worse while drunk from the effects of alcohol. This project (like almost all marihuana research) has met with criticism for faults in methodology. Many authorities have concluded that the distortions in time and space produced by heavy marihuana smoking make driving an extremely hazardous undertaking. Continued heavy use of marihuana may also produce the possibility of hallucinating while driving. Even marihuana fanciers do not recommend going out for a drive as a safe or suitable pastime while under the influence of pot. The recent book, *A Child's Garden of Grass*, which encourages the use of marihuana, specifically warns against such undertakings as driving automobiles and descending long flights of stairs.

Driving under the influence of any intoxicant is hazardous but operating an automobile or other machinery after using marihuana is especially dangerous. Marihuana slows the reflexes, impairs coordination and distorts the sense of time and space. A minute seems to be an hour; space may seem to be greatly expanded. This means that even the skilled and experienced automobile driver may have difficulty in determining how far he is from another car and how much time he has to execute a particular maneuver. The drug also removes inhibitions and can cause a state of euphoria in which the user's attention becomes fixed on a particular object and excludes all others; and because the drug (especially in heavier dosages) can cause hallucinations, the driver may be unable to determine what is actually in front of him on the road. Dr. Edward Bloomquist told the Commission of a recent tragic accident in California in which the operator of an automobile began to hallucinate while driving. Looking out his left door window, he imagined that he saw a white dove flying parallel with the car.

Stella brand cigarette papers give off a distinctive sweet cherry flavor.

Having lost cognizance with the fact that he was driving a car, he let go of the steering wheel, rolled down his window, and tried to capture the dove. Needless to say, there was no dove and his hallucinating resulted in a horrible accident.

This problem exists with a casual or occasional user of marihuana as well as it does with the chronic user. It is parallel to the situation that while only 4 per cent of the drivers are alcoholics, more than 50 per cent of fatal

accidents involve alcoholics. The person driving under the influence of marihuana is a hazard as great as, or greater than, the person who drives after drinking alcohol.

Subjectively, the user experiences one or more of the following effects: a feeling of well-being, hilarity, euphoria, distortion of time and space perception, impaired judgment and memory, inability to reason in the abstract, and confusion.

According to Dr. Nathan B. Eddy, a leading authority on drug dependence, and a technical consultant to this Commission, after repeated administration and high dosage, other effects of marihuana are noted, such as:

> . . . lowering of the sensory threshold, especially the optical and acoustical stimuli, thereby resulting in a feeling of intensive appreciation of works of art . . .; hallucinations, illusions and delusions that predispose to anti-social behavior; anxiety and aggressiveness as a possible result of various intellectual and sensory derangements; and sleep disturbances.

While some persons assert that marihuana improves artistic and other creative endeavors, there is no evidence that this is so. The drug merely reduces inhibitions and beclouds one's own appreciation of his efforts.

Notwithstanding this fact some persons "give witness" to creative insights in a new found purpose and zeal in life following drug use. Many users even become "marihuana missionaries." Consider these "natural laws" of the leading psychedellic missionary, Timothy Leary:

> I. Thou shalt not alter the consciousness of thy fellow man.
>
> II. Thou shalt not prevent thy fellow man from altering his own consciousness.

Leary claims he did not invent these commandments:

> They are revealed to me by my nervous system, by ancient, cellular counsel. Ask your DNA code. I urge you to memorize these two commandments — nothing less than the future of our species depends upon our understanding of and obedience to these two natural laws.

The assertion that marihuana is a mind expander, that it "turns on" creativity, may well turn out to be an insidious liability. While there is some foundation for the view that marihuana produces a *feeling* of creativity, this is quite different from creativity itself. For example, as pointed out by jazz drummer Gene Krupa above, musicians perceive that they do better when high, but the available evidence suggests just the reverse. If artists' and musicians' fame were dependent on marihuana-inspired creativity, our belief is that they would for the most part remain unrecognized, save possibly to an audience intoxicated with marihuana.

The ordinary creative process in society, as found in literature, art, music, and science has been viewed as consisting of four stages: (1) a stage of *preparation* often requiring years of effort in the acquisition of technical skills; (2) a stage of *frustration* characterized by rising emotionality, listlessness, feelings of inferiority, neurosis and even abandonment of the problem for other activities in the sheer defense of emotional balance; (3) a stage, or moment, of *insight* accompanied by a flood of ideas, almost hallucinatory vividness of thought and feelings of expectation; (4) a stage of verification, or confirmation, in which the new found "insight" is checked against external realties and exaggeration and overstatement are modified.

Suppose, for the sake of argument, that marihuana *does* cause a feeling which mimics the period of insight of the third stage without the genuine work and time required in the creative process. We might then predict that the marihuana user will wish to repeat the pleasant experience for hedonistic purposes, but woe to his attempt to communicate to others the value of drug induced "creative insight."

It has been demonstrated that marihuana may uncover longings for omnipotency and suggest, as well as provide, a false sense of self-confidence. This is illustrated in the following recorded experience of an intoxicated person who believed he was creating a great novel:

> I am giving you the thoughts; slap them down, we'll make a fortune and go whacks. We'll make a million — Take down everything that is significant — with an accent on the *cant* — Immanuel Kant was a wise man, and I am a wise man; I am wise, because I am wise.

In spite of all the gabble concerning the volume that was to bring fame and fortune, not even one line was dictated by the inspired author. In fact he never got beyond the title:

"Wise is God; God is Wise."

This nonsensical excerpt is taken from Victor Robinson's "Experiments with Hashish." It appears in a collection of articles entitled, *The Marihuana Papers*, edited by David Solomon.

This feeling of accomplishment and superiori-

ty was noted in a study of 35 confirmed marihuana users who were failures in the army. They were deferred during World War II for medical treatment because of inadequate performance of their duties. Nonetheless many of them felt themselves "superior" to their fellow soldiers. In this regard the following account of the 35 subjects' thoughts and attitudes is pertinent:

> The rest of the world, the 'squares,' allowed themselves to be limited to the earth, whereas they [the marihuana users] could transcend it. In this way they take on the traditional attitude of the creative artist or "the Bohemian" but without the need of even making a pretense of creating. They themselves are the supreme creation, and they do not feel any need to justify their existence by soiling their hands with work. They repeatedly state, "I don't go for work," or, "I wasn't cut out for work."
>
> There were repeated statements that marihuana improved their health, increased their strength, enhanced their sexual potency and gave them feelings of power over women and other challenging situations.

In short, the use of marihuana seemed to enhance their self-image and make them unconcerned with the real world and its dangers. Although this study is somewhat dated (it was conducted in 1944), the observations are equally valid today.

Some observers report that the use of hallucinogens by college students leads them to feel superior to their professors and regard examinations as beneath them. The outcome may be that they become college dropouts. Timothy Leary asks you to consider:

> The new cult of visionaries. They turn on, tune in and often drop out of the academic, professional and other games-playing roles they have been assigned. They do not drop out of life, but probe more deeply into it, toward personal and social realignment characterized by loving detachment from materialistic goals.

Those who preach that marihuana promotes insight might be opening a Pandora's Box with regard to creativity. We believe this would be especially so if the user has the illusion that marihuana will be a substitute for adequate preparation and the frustrations often associated with the creative process. The assertion that marihuana causes a user to "tune in" and "turn on" a creative experience is no more justified than the statement that marihuana leads one to "fade out" and "turn off" with respect to recognizable creative accomplishment.

The majority of persons of recognizable creativity deny the value as well as the use of drugs to assist their creativity. While it is true that some persons do attribute their creativity to drug use, it also appears that such persons have studiously prepared themselves and have usually been creative *before* the use of drugs.

There is little difficulty in recognizing the intoxication of a person who has smoked a significant amount of marihuana in the preceding few hours. Speech and thinking have been slowed down, bodily movements are frequently slow and exaggerated. Frequently the intoxicated person displays extreme hilarity and may giggle incessantly.

It is much more difficult to recognize a nontoxicated marihuana dependent person or experimenter. As indicated earlier, there is no physical dependence, and hence no withdrawal syndrome. Subtle evidence of neurologic impairment may be obvious in the case of some very heavy smokers. This impairment will sometimes consist of slurred speech, staggering gait, hand tremors, thought disorders, and disturbance in depth perception. Chronic smokers will often exhibit very poor social judgment, poor attention span, poor concentration, confusion, anxiety, depression, apathy, passivity, and indifference. Less often there may be an alteration of consciousness and inability to bring thoughts together and to reason in the abstract, a paranoid suspiciousness of others, and a regression to a more infantile state. Changes in life style may also be apparent. These might include the onset of sexual promiscuity, marked difference in personal cleanliness, grooming, dressing, and study habits or work, or both. The observer, however, must be careful in this latter category to make attribution to the use of marihuana. Such changes in morality and life style may be entirely unrelated to the use of cannabis.

Most persons who use marihuana do not experience adverse effects other than the discomfort caused by the burning substance, the taste, and the acrid smoke. Most occasional users experience only mild relaxation and euphoria. No one denies, however, that a marihuana experience can be a "bummer." Instead of euphoria, a pot smoker may feel extreme depression, anxiety, and even serious alarm. "The drug is especially apt to trigger such reactions in people with unstable personalities or emotional difficulties," according to Dr. Dana L. Farnsworth, head of the Harvard University Health Service, who is a strong believer in legal suppression of marihuana.

It is also possible for a marihuana smoker to suffer an acute form of bad trip, in which the user shows signs of temporary derangement. By all accounts, the phenomenon is quite rare. According to Dr. Andrew Weil, who has studied marihuana for several years, almost all "psychotic" reactions are in fact very severe panics. Usually they are suffered by people who are "turning on" for the first time and "interpret the physical or psychological effects of the drug to mean that they are dying or loosing their minds." The panic will subside as the effects wear off. These panic reactions will be eased if the person is simply reassured that his experience is natural for marihuana smokers and will disappear within a few hours.

Toxic overdoses of marihuana have been known to produce psychotic effects. Reactions involving hallucinations, paranoia and disorganization of thought have been known to last for days or even weeks.

But it is the typical marihuana smoker who limits his intake in order to get pleasantly high and no more. Overdoses are reported mostly in cases where someone has eaten the substance (usually baked into cookies or in laboratory experiments in the form of pure THC) and hence been unable to regulate his high. Authorities, however, have experienced alarm over the recent influx of unusually potent cannabis grown in Southeast Asia. It has been shown, for example, that some Thai marihuana is three times as strong as high-grade Mexican varieties. Since most marihuana smoked in the United States is locally grown or imported from Mexico, most smokers are unaccustomed to the much more powerful varieties imported from the East. Even assuming that today's normal social high may be relatively harmless, one wonders what may happen if the stronger strains or even pure THC become available.

Today it is generally agreed that marihuana is not always necessarily a "stepping stone to harder drugs." Marihuana may not create a physical craving for harder drugs, but many experts believe that it does kindle a fascination with the psychedellic experience that leads users to experiment with the more dangerous drugs. Some studies have indeed shown quite a high proportion of such experimentation, at least among heavy smokers. In one survey of 200 chronic cannabis users, 49 per cent had tried LSD, 43 per cent an amphetamine, and 24 per cent a barbiturate. In all, two thirds of the heavy smokers had used another illegal drug.

Some authorities familiar with marihuana habits contended, however, that this is not the case for the ordinary smoker. "It simply isn't true that marihuana leads to other drugs" according to Dr. Reese E. Jones, a marihuana researcher who is a Professor of Psychiatry at the University of California Medical School. "The use pattern we usually see is people going from alcohol to marihuana and LSD, then giving up the LSD and settling on a pattern of marihuana, wine and beer." Others note that there is no reason to believe that marihuana smoking leads to narcotic addiction simply because the addict happens to have used marihuana first. Dr. Norman Brill, a Professor of Psychiatry at UCLA, recently completed a drug study of 1,500 undergraduates. He concluded that no cause and effect can be established between early marihuana use and later narcotic addiction. The largest study thus far conducted on the problem was recently completed by the Na-

A joint is twisted at both ends since marihuana is a very base substance and cannot be packed in the same way as a tobacco filled cigarette. The papers above depict miniature ersatz one hundred dollar bills. With these the smoker can indulge in the imaginary extravagance of burning money as he enjoys his "pot."

tional Institute of Mental Health. It was their finding that approximately one out of five marihuana smokers will eventually gravitate to more dangerous drugs.

Most of the older studies indicate a fairly alarming link between marihuana use and abuse of other drugs. It was shown, for instance, that 70 per cent of 2,213 opiate addicts admitted to the United States Public Health Service hospitals at Lexington and Fort Worth during 1965 reported a history of marihuana use. From interviews with 337 of these patients, it was found that the dominant sequence of events was marihuana smoking followed by opiate use.

Although marihuana use is neither a necessary nor sufficient condition for opiate addiction, it may be a contributory influence. The self-administration of one illicit drug predisposes the user to try other drugs, especially when this is done in a group setting for hedonistic purposes. Thus, according to the above government survey, it is not uncommon for the neophyte to be introduced to both marihuana and heroin by the same group of friends:

> Case No. 211. — The very first time he tried drugs, it was marihuana. It happened one night when he was going out with a couple of friends to a party. One of them got hold of some cigarettes and they decided to try it. At first, he didn't get any "kicks" out of it, but the others seemed so excited, he decided to keep trying it. After that first night they would get together mostly on weekends and smoke marihuana. About three months later he tried heroin.
>
> Case No. 147. — The subject had his first experience with marihuana at age 22 while in New York City after his discharge from the army. He said he was living in a neighborhood where most of the kids were using marihuana. He was going around with this crowd until one night he decided to try it himself. They went up to one of the fellow's rooms and smoked marihuana. He went on using marihuana almost every day for a couple of months before he used heroin. He used heroin with the same crowd. He said that two of the fellows were heroin addicts, and they were also selling.

It should be emphasized that case studies such as this do not prove that marihuana use leads to opiate addiction. The difficulty with this sort of statistic is that its results show a "reverse" research direction. That is, persons who are already confirmed opiate addicts are queried as to the origins of their abuse. At best, this sort of resarch can only substantiate what percentage of addicts were also, at one time or another, users of marihuana. Thus, it can be said that marihuana does *not* lead in a causal manner to the use of opiates. In the estimation of Dr. Stanley Yolles, former Director of the National Institute of Mental Health, probably no more than 5 per cent of marihuana users go on to heroin use. However, the use of the two drugs is associated in the following ways:

The ubiquitous "Mr. Zig-Zag" is pictured above on a white T-shirt. His image represents a protest against laws restriciting marihuana use.

1. The black market profit on hard-core narcotics is *quite* high; the profit on marihuana is low. The dealers therefore try to persuade their customers to switch from low profit marihuana to high profit morphine and heroin.
2. Persons who are members of the drug subculture are likely to experiment with whatever drugs are available.
3. Persons with severe emotional problems may find that marihuana, although initially giving them some relief, does not give enough and they may then turn to stronger drugs because of their power to mask unpleasant reality.

Rather than assuming marihuana to be the significant factor in the escalation to opiate addiction, we think it more likely that introduction into the drug subculture, with its emphasis on drug experimentation, is the most influential factor. Yet it must be admitted that a person who does not start with one of the milder drugs is not likely to become involved with the stronger ones.

Most persons who continue to use marihuana have emotional problems that they are attempting to hide through drug use. Moreover, they move in a culture whose main source of esteem and manner of life is drug experimentation. Their psychological difficulties are such that they will try any drug available: hallucinogens, narcotics, barbiturates, amphetamines, alcohol. This is not a physical process of causation. The association of marihuana with these other drugs is a complex psychological and social association which is based on the individual's emotional problems and the group pleasures exercised by a subculture which is almost exclusively involved with all sorts of drugs.

What is not known at present is the long-term effects of continual marihuana use upon the persons who use this drug and who do not graduate to "hard narcotics." What will happen to the college student who becomes a daily marihuana user? Is the solitary user different from the common peer-group abuser? Does continued marihuana use lead to an alienated and nihilistic orientation to life? Or, conversely, does alienation lead to marihuana use?

As mentioned previously, the continued heavy use of marihuana will eventually produce a psychological dependence. There is no question that confirmed, heavy pot heads have a marihuana "habit." This amounts to a dependence on the drug for their psychological well being. The question presents itself as to how the marihuana habit differs from many other common habits. Dr. Graham Blaine, Chief of Harvard's Psychiatric Service, states that continued marihuana smoking is a habit, but one which is quite easily broken.

Many medical authorities think the marihuana habit, whatever one may think of it in adults, is decidedly worrisome when adopted by adolescents to escape the special problems they confront. Dr. Stanley F. Yolles, former Director of the National Institute of Mental Health, has argued that, "Persistent use of an agent which serves to ward off reality during this critical developmental period is likely to compromise severely the future ability of the individual to make an adequate adjustment to a complex society."

Dr. Thomas Ungerleider, Professor of Psychiatry at UCLA, is one of the many authorities who point to the "amotivational syndrome" among "grass" smokers. It contains elements of passivity, concentration on present pleasure rather than future goals or hard work and a lack of ambition and initiative. To some, this is the most disturbing feature of the pot culture. Mr. Eugene Rossides, Assistant Secretary of the Treasury, in charge, among other things, of combating drug smuggling has argued against marihuana legalization on these grounds. He has warned that, "If we should ever, in a wild moment, decide to legalize marihuana, I think we could sap the strength and energy of a whole nation." Rossides also suggests that, "Any disrespect for the law would be minor compared to the lack of drive, goals and ambition that legalization could produce. I really think it could make the United States a second-rate nation." The apathy producing qualities of cannabis have frequently been cited as a causation for the failure of many countries in Asia and Africa to achieve a fully industrialized society.

Dr. Bloomquist has suggested that one reason for Nigeria's recent advance in industry is that that country has outlawed cannabis. Indeed, the selling of marihuana in Nigeria is now a capital offense.

In reference to the apathy producing qualities of marihuana it has occasionally been argued that persons who make heavy use of cannabis are "apathy-prone" individuals at the outset. Thus the question becomes, which came first, the marihuana or the apathy? Dr. Reese Jones has asserted that, "Often the listlessness and lack of motivation precede use of marihuana." This is a difficult issue to prove since adequate research methodology is lacking.

Most authorities, however, are in agreement that persistent use of marihuana does lead to substantial deterioration of motivation. Several graphic examples of this were brought to the Commission's attention during its tour of California drug facilities. Dr. Henry Bruyn, Director of Student Health Services, University of California at Berkeley, has encountered many examples of the "amotivational syndrome" in treating students at the University. The same observations were also voiced by Dr. D. Harvey Powelson also of the University of California at Berkeley. Their views are discussed in greater detail in Chapter 12 of this Report.

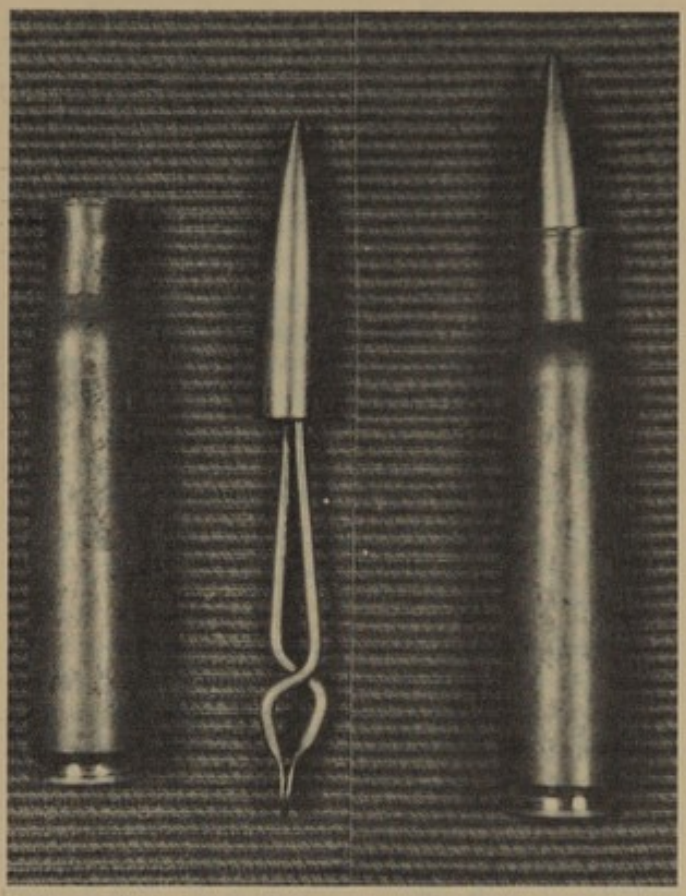
These apathy-promoting qualities of marihuana are not permanent, however. Depending on the length of experience with the drug, these qualities disappear as the residual traces of the drug leave the body. Dr. Robert Harris, Chief of Behavioral Pharmacology at the Texas Research Institute of Mental Sciences in Houston, has done considerable work in this area.

He has stated that use of marihuana in substantial quantities will produce lethargy but that this condition will vanish with discontinued use of the drug.

Apart from the lethargic qualities of marihuana it has also been shown that the ability to reason in the abstract is substantially impaired through heavy usage of cannabis. Moreover, the University of Texas at Galveston released a study which indicates that "regular, heavy use of marihuana may disturb brain function." The research also showed that clinically-controlled experiments with humans and research animals showed brain abnormalities after heavy doses of marihuana. The research team cautioned, however, that their study is of a preliminary nature and that no firm theories of cause and effect had yet been established. It is emphasized that all references to apathy promotion and disturbance of brain function refer only to the heavy continued use of the drug. Limited, occasional use of marihuana probably has little or no effect upon one's reasoning ability after the "high" has ended. A recent study prepared for the Massachusettes Commission on Drug Abuse covered a sample of 320 students at four colleges. Roughly half had smoked marihuana. The academic grades of those who smoked it regularly turned out to be slightly higher than those of non-smokers.

In the area of career plans an equal number of smokers and non-smokers indicated that they planned to go into medicine or the law; 60 per cent of the smokers, but only 48 per cent of the non-smokers, were studying for careers in government and public service; 22 per cent of the non-smokers, but only 8 per cent of the smokers, were planning to enter business or science. Of course, the results may tell as much about the people likely to try pot as about the effects on those who smoke it. Other studies have shown the reverse of the Massachusettes experiment. That is, marihuana smokers have been shown to have lower academic standing than non-smokers. Very likely this is but yet another example of the inherent difficulties in conducting marihuana research. It is impossible to determine what constitutes "regular use" of marihuana from one study to another. Worse, it is impossible to determine the relative potency of the marihuana smoked by individuals tested within the same survey much less to compare separate studies.

These facts underscore the all important observation that the effects of marihuana depend entirely on the dosage. The smoking of marihuana is a process in which the active ingredient is taken in small portions in each inhalation. The expert user thereby has a greater opportunity to achieve a "controlled" high than the drugs taken in a single dose such as the ingestion of LSD or the "shooting" of opiates into the veins. The inexperienced user may be unaware of the methods by which cannabis smoke is inhaled and held in the lungs. For this reason his initial experiences with the drug may be quite insipid compared to those of the devotee. More importantly, the type of preparation used and the quality and origin of the cannabis are crucial in measuring the degree of reaction to the drug.



Marihuana cigarettes are smoked to the very nubbin since the final puffs on the butt or "roach" are highly cherished by smokers. "Roach clips" have been devised to hold the hot morsels. The one above, known as a "bullet for peace" appears to be an ordinary bullet, but when disassembled, it contains a roach clip.

Individual experiences vary widely. Acute physical symptoms frequently include conjunctival vascular injection, dryness of the mouth and pharynx, irritation of the throat, increased sensitivity to light, sound, touch, and pain stimuli, and such changes in the autonomic nervous

system and increase in pulse, blood pressure and tendon reflexes. Ataxia, the impaired ability to coordinate voluntary muscular movements, may also occur. Appetite is often stimulated. As indicated previously many smokers report an increase in sexual potency although there has been no firm evidence to support this assertion.

Although there is some disagreement among the authorities, there appears to be very little change in respiratory rate, pupil size and blood sugar levels attendant to the use of cannabis. There are as yet no recognized lasting ill effects directly attributed to the brief use of marihuana. Although lethal dosages have been established for animals, there has never been a human death reported in this country due to overdose.

Depersonalization, the perception of the physical body as somehow apart from one's self, has been described with use. While this distortion might be expected to increase the likelihood of self-injury, we know of no documentation to confirm this expectation.

Increased suggestibility, decreased judgment, and change of affect may be followed by depression and sleep. There may also be delusions, hallucinations, suspiciousness, panic and fear of death. Violent or aggressive behavior has occurred in some instances but is generally quite rare. While some persons may be especially sensitive to very small doses, with a result that a psychotic-like state is produced, there is recent evidence that almost all persons are so affected with sufficiently large dosages. A puzzling observance is that many of the persons who have had frightening episodes in their marihuana experiences wish to repeat it.

In summary, the immediate acute effects of marihuana smoking commonly include a euphoric state accompanied by motor excitation and mental confusion. These reactions are often followed by a period of dreaminess, depression, and sleep. The wide variety of individual reactions appears to be more closely related to personality differences (including expectations and emotional arousal) and the cultural setting of use than to any specific property of the drug itself.

Even though there are an estimated two hundred million users world wide, predominantly in Africa and Asia, the long-term effects of marihuana use have not been sufficiently studied to permit valid generalization. While physical deterioration, lethargy, and social degradation have been observed among the chronic cannabis users of India and Africa, it has not been established that the deleterious effects were not related to inadequate nutrition, disease, subcultural norms, or other influences.

No research has been done in the United States to establish the presence or absence of a chronic marihuana syndrome. Thus, the absence of a well-defined chronic syndrome among cannabis users at the present time does not establish that marihuana is safe. The extent of long-term ill effects are probably determined by the duration in frequency of use and the potency of the drug abused. The absence of a well-defined chronic syndrome in the United States might be accounted for by restricted availability of the drug, the practice of smoking only to a "controlled" high, or other factors.

Similarly very little research has been done in other areas of possible permanent health impairment through the continued use of marihuana. Very little is known about the biological and metabolic effects of cannabis. The question of pulmonary toxicity (whether marihuana damages the lungs) is just beginning to be explored. Initial results have shown, however, that smoking marihuana is probably many times more hazardous than smoking tobacco. There are also some indications that liver problems tend to occur among chronic marihuana smokers. A recent British study conducted by William Paton, Professor of Pharmacology at Oxford University, indicated that chronic use of cannabis probably results in liver damage.

Dr. Vincent DePaul Lynch, who conferred with the Commission on several aspects of the drug problem, has just completed an intensive study on the teratogenic effects of cannabis sativa on the mouse. In research conducted at St. John's University in New York Dr. Lynch's study showed that pregnant mice that breathed marihuana smoke had produced offspring with serious genetic defects. Dr. Lynch's tests corroborate previous experiments conducted in the British West Indies and Augusta, Georgia. Although little has been done to link marihuana use with *human* genetic defects, Dr. Wesley Hall, the President Elect of the American Medical Association, recently noted that the incidence of birth defects in infants whose mothers habitually smoked marihuana is "definitely far higher" than normal. Numerous studies are currently under way which will eventually reveal whether marihuana causes changes in the chromonsonal patterns (as recently reported with respect to LSD), or other subtle physical changes.

Research

Currently there are dozens of research projects under way to determine exact information about the immediate and long range effects of cannabis use. Perhaps the leading research organization is the National Institute of Mental Health (NIMH). Currently NIMH is pressing forward with a host of studies including injecting various animals with the drug in various doses and surveying longtime users in Jamaica and Greece. There is some interesting work under way, too, on the possible potential benefits of marihuana. A small minority of doctors think that it may be useful as a mild tranquilizer and anti-depressant. Recently a medical research team at the University of Vermont began a series of experiments with marihuana as a replacement for painkillers and anti-depressants among cancer patients. Moreover, several research physicians have suggested that it might be helpful in reforming heroin addiction. Some medical literature suggests that THC may be useful in chemotherapy among opiate addicts.

Despite the significant beginnings much remains to be learned about marihuana, hashish, and related materials. Little is as yet known about the implications of chronic use, particularly at lower dose levels and at less frequent intervals. Although much can be learned from animal research, in the final analysis the most crucial information with respect to long-term human use can only be obtained by careful observations of clinically using groups in the United States and abroad.

It is important that we learn more about the possible interactions between marihuana use and that of a wide range of other drugs. This includes not only such drug substances as caffeine, tobacco and alcohol but also other drugs of abuse and a large group of therapeutically employed drugs. As use of marihuana comes to include a wider spectrum of the population, it is important that we learn its effects on those who physiological functioning is to some degree impaired or who suffer from physical or psychological disabilities. Such effects must be studied over a wide dosage range and in various use patterns.

From a psychosocial point of view it is essential that we come to better understand the different patterns of drug use, their implications for social functioning and those factors which contribute to such use. These include parental attitudes, child rearing practices, and peer pressures as well as those aspects of subcultural and cultural practices that may affect use. Finally, it is imperative that we determine what are more effective prevention and education techniques that serve to avert drug abuse of all types including that of marihuana.

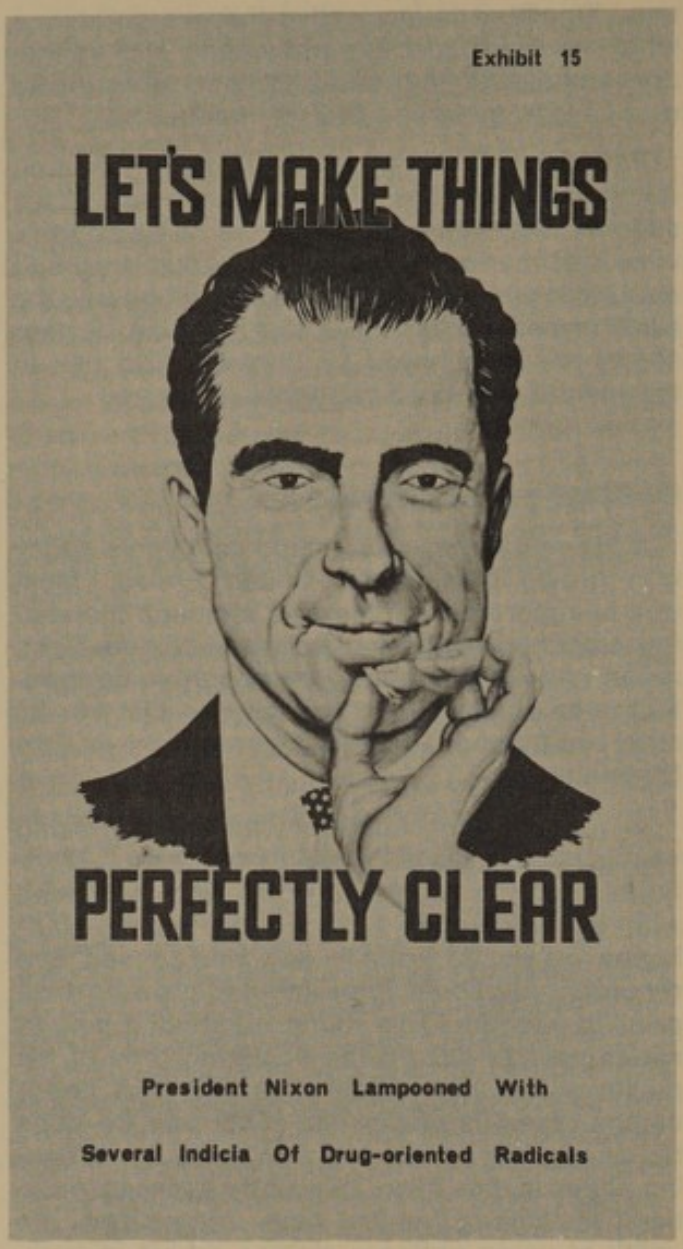
For the time being, although much research remains to be done, most medical authorities support the American Medical Association's view that marihuana is "a dangerous drug and as such a public-health concern." Similarly, the NIMH recently reaffirmed that, pending further study, the drug "must be considered a risk to the mental and physical health of users."

Cultivation and Traffic

Most marihuana purchased in Illinois today was grown outside the United States. Most of it is imported from Mexico, although increasing amounts have been traced to Middle East, Asian and African origin. Although some marihuana is locally grown, it is held in disfavor by most marihuana smokers because it is lacking in potency.

In recent years, however, many enterprising youths have taken to "growing their own." Marihuana can be planted, grown and harvested with a minimum of horticultural talent. Marihuana grows in virtually any kind of soil and requires only about three months growing time prior to harvest. The young marihuana grower needs only to cut off the flowering tops of his plants at the appropriate time and then find a means of drying them out. This can be done by simply leaving them out in the sun, or baking them in the oven. Recently growing numbers of Illinois youths have recognized the utility of using ordinary clothes dryers in laundromats to dry their "precious" marihuana. An agent of this Commission recently received a complaint from a South Chicago laundromat owner that youths were apparently using his dryers for non-laundry purposes in the early hours of the morning before regular patrons would arrive. These people had become angered over the fact that dryers were unusable because of the presence of a strange green plant substance which was adhering to their clothing. A chemical analysis of the crushed green plant revealed it to be marihuana.

The fact that more people do not grow their own marihuana is probably attributable to the omnipresence of the police and other drug enforcement agencies. Most law enforcement people are very familiar with the appearance of marihuana and are usually quite diligent in eradicating it. Most of these efforts, however,



The frequently used phrase of President Nixon is satirized here with several indicia of drug-oriented radicals, such as a marihuana joint and a "stars 'n stripes" tie. The view expressed here is that one's understanding is enhanced through the use of cannabis. Pharmacologically, the opposite is usually the case.

take place in urban areas. Marihuana growth in rural regions is largely unchecked.

Many thousands of acres of cannabis sativa are growing on farms, railroad rights of way, ditch banks and other waste places in Illinois and across the Midwest. Champaign County alone has an estimated 1,000 acres of wild marihuana on farms and other lands capable of yielding up to 3,000 tons of pot annually.

Post pushers and users from 14 states have been arrested trying to harvest the Champaign County crop. In adjoining Vermilion County, the Illinois Department of Agriculture estimates that one million dollars worth of wild pot was destroyed in a pilot spray program.

Efforts have recently begun by various farm organizations to encourage farmers to recognize and eradicate wild marihuana growing on their land. In the State of Kansas 4-H Club youths are being taught to identify and eradicate marihuana.

Currently programs to eradicate wild marihuana are under way in four Illinois counties. State and federal officials who are cooperating with the counties hope the programs will set patterns for expanded campaigns throughout the Midwest to destroy thousands of acres of the weed. The Illinois Department of Agriculture and the University of Illinois Agricultural Extension Service are cooperating with county supervisors and sheriffs in DeKalb, Champaign, and Vermilion Counties. Henderson County is just one of 11 counties in 10 states selected for a pilot cost sharing program to pay farmers to destroy wild marihuana.

Although details vary in the respective counties, the programs reflect increasing concern among local, state, and federal officials over the lack of success in getting land owners to eradicate marihuana. The plant received a firm foothold in the Midwest as a result of government efforts during World War II to encourage farmers to grow hemp as a commercial crop. The wild marihuana still thrives in uncultivated waste places as a legacy of those efforts.

The state is currently paying salaries to part time marihuana control officers, and is providing plant sprays in DeKalb, Champaign, and Vermilion Counties. The Federal Bureau of Narcotics and Dangerous Drugs also provides some funds for the Champaign and Henderson Counties programs.

Compared to the hazards of growing one's own marihuana the dangers of smuggling it are even greater. This is particularly true of efforts to smuggle marihuana from Mexico into the United States. Although customs authorities cannot, of course, intercept all of the marihuana coming into the United States a significant number of seizures are made annually. Moreover, there is the added risk that one's "source" in Mexico will have no qualms about informing customs agents about the contraband on his person. These informants receive a

sum based on the value of the marihuana seized. The same condition exists in other countries overseas where extremely stringent penalties have been established for traffic in cannabis. At this moment there are dozens of Americans incarcerated in foreign prisons on marihuana convictions. Most of these persons were not true criminal traffickers in drugs. They were, in fact, largely typical Americans who were naively unaware of the extremely austere approach to cannabis taken by other countries of the world. The State Department has made numerous efforts in recent months to advise American travellers of these heavy smuggling penalties.

Procurement

Marihuana is incredibly easy to procure in Illinois — particularly in Chicago. Wherever large numbers of young persons congregate one will invariably find a marihuana outlet. In virtually all cases the pot seller is also a user.

It is not too difficult for one to buy marihuana in Chicago in a matter of hours unless he happens to be over 35 or is a newcomer to town. Marihuana sellers are suspicious of older people and persons who are obviously unacquainted with the locale. However, even the "elderly" pot seeker of 35 can usually procure marihuana if he is persistent in his efforts.

For many the act of buying cannabis is even more exciting than smoking it. There is a certain thrill in dealing with the "criminal element" and skirting the "narks" (narcotics agents). Most people buy marihuana in relatively small quantities. They are usually looking for no more than enough to satisfy a weekly or monthly smoking habit.

The price of marihuana varies greatly from time to time and from place to place. Since cannabis is more plentiful in the fall the price is usually lower. Moreover, the price usually decreases the closer one gets to Mexico. Another major influence on the price of pot is the degree of local law enforcement activity.

Marihuana may be packaged in countless ways. Two of the more familiar ways, however, are in cellophane cigarette packages and in small match boxes. As might be expected these containers are referred to as "bags" and "boxes" by marihuana users. When one announces his desire to purchase marihuana, he usually makes his preferences known in terms of the quantity desired. Thus, a smoker who desires a typically small quantity, such as the amount necessary to make eight to ten marihuana cigarettes, will announce that he is looking for some "bag or box action." One may also announce his desire in terms of price. Hence the term "nickel" or "dime" bag may be used to denote one's desire to purchase a $5.00 or $10.00 quantity of marihuana.

In general, the next largest amount is usually packaged in a larger plastic bag, an old tobacco can, or a "lid," an amount roughly equivalent to the contents inside a tobacco can lid.

Ingestion

Marihuana may be ingested in any number of ways. The methods used are limited by the user's imagination and originality. Cannabis may be eaten, drunk, sniffed or inhaled through smoking. Marihuana is usually eaten in combination with some other food stuff. Most commonly it is mixed with items such as candy, cookies, and brownies. Instances have also been reported of marihuana being mixed in salad dressings, soups and "chip dips." It may also be intermingled with beer or wine and drunk. The pure resin may be reduced to a powdery substance resembling tobacco snuff and then inhaled through the nose.

The most common method of ingestion, however, is by smoking. Usually the marihuana is in a crude state. That is it contains a large amount of stems and seeds. For this reason it is frequently necessary to "manicure" one's marihuana. Manicuring is usually accomplished by sifting the marihuana through a screen. After the marihuana has been manicured it is ready to be rolled into "joints" (marihuana cigarettes) or put in a pipe.

Unlike tobacco, marihuana does not remain easily lit. It requires a degree of attention to keep the joint ignited while smoking it. Occasionally marihuana will be mixed with conventional cigarette tobacco in order to make the marihuana "go farther." This is a difficult process, however, since the two substances are completely dissimilar and do not blend easily.

If manicured in a sufficient degree marihuana can be smoked in a "small bowled pipe." A small, shallow smoking container is necessary because of the difficulty in keeping the marihuana lit. It is much easier to smoke hashish in a pipe because this latter substance is much finer than marihuana and more easily ignited. As mentioned previously in Chapter 3, a wide assortment of pipes are available at numerous

"head shops" and tobacco stores in virtually all metropolitan areas in the State of Illinois. These pipes are generally quite small and inexpensive. In addition to conventional pipes a number of Eastern smoking devices such as the hookah water pipe have been used in recent years.

Marihuana is usually smoked in a social setting. That is, two or more persons will be present in a room or car. For a heightened effect veteran users will sometimes smoke marihuana in a small closet. The advantage here, obviously, is that marihuana fumes tend to concentrate in a small area, thereby enhancing "enjoyment" of the cannabis.

The marihuana joint usually has the appearance of a small skinny cigarette. The marihuana is usually rolled in wheat paper or convention "rolling" paper used to roll ordinary cigarettes. These papers are sold by tobacconists and head shop proprietors. Frequently the cigarette will be double wrapped to insure confinement of the marihuana smoke. "King size" marihuana cigarettes are almost nonexistent. In addition to the fact that most cigarette paper is quite small marihuana joints are intentionally kept small since the cannabis tends to burn more rapidly and are less expensive than thick joints.

Before smoking, the joint is carefully inspected for flaws. An important consideration is that no twigs have perforated the paper. This permits gasses to escape and makes smoking more difficult.

In his book, *Pot: A Handbook of Marihuana,* John Rosevear describes the use of the marihuana cigarette with compelling accuracy.* After selecting the end to be lighted, he advises, the smoker wets the joint with saliva. He may roll it around his lower lip; He may lick it with his tongue; or he may "let it all slide in." Rosevear continues, "Often the joint is a grey, soggy thing, repulsive looking, sad, and unsanitary but the wetting moistens the joint and slows down the burning process."

The marihuana joint is not lit like the conventional cigarette. Instead of lighting the joint while it is still in one's month, it is usually held in the fingers at eye level and then lit while the cigarette is turned slowly. This assures an even distribution of the flame.

Once the joint is lit it is kept in constant use. At any given "pot party" any number of joints may be in use. One or more communal cigarettes will be passed about the room from one guest to another. In more opulent gatherings more cigarettes will be in evidence. Sometimes a single smoker will inhale two cigarettes simultaneously. This is called a "double header." Each smoker will drag (inhale) deeply on the cigarette. The object is to hold the smoke in one's lungs as long as possible flushing it down with short breaths until the lungs are filled to capacity. Novices are usually advised to retain the smoke "until it hurts." The purpose of retaining the smoke in one's lungs for long periods of time, apart from the economy involved, is to effect a rapid and full alveolar transfer of the tetrahydrocannabinols to the blood stream. "The object of marihuana smoking," advises Rosevear, "is to get the smoke into the lungs in the most efficient way, taste and flavor be damned. The throat is opened and the smoke drawn directly into it."

In a few minutes the joint has burned down to a small butt. This highly prized item is referred to as a "roach." Its value arises from the fact that it is saturated with tetrahydrocannbinols which have concentrated during smoking. As may be expected the roach is very tiny, very hot, and very hard to handle. To adequately savor the marihuana one must hold the roach with a paper clip, tweezers or a specially made roachholder. Holders are available in all head shops. Because the roach is so small and hot it is not held by the lips. Instead it is held close to the mouth and the smoke is drawn in by rapid inhalations through pursed lips. These concentrated fumes, like the others, are held in the lungs as long as possible to acquire the desired effect. The roach may also be smoked at the end of a cigarette. Or an accumulation may be saved and combined into a full joint. The method is the choice of the smoker.

Marihuana and Crime

The possession or distribution of marihuana is a criminal offense in Illinois. Thus anyone who possesses or deals with marihuana in any way, is by definition a lawbreaker. Beyond

* It is noted parenthetically that Rosevear's book has been a persistent source of notoriety since it was first published in 1967. Several school boards, particularly in the Southern states, have taken steps to remove the book from library shelves because it goes into great detail on how to grow, process, and smoke marihuana. Moreover, it speaks glowingly of the pleasures of being high on marihuana. Despite its unquestionable evangelism, the book provides extraordinarily detailed information on marihuana and the subculture it has spawned among our youth.

this, the question arises as to whether marihuana use is associated with other types of criminal behavior. Does the violation of marihuana laws predispose or compel an individual to commit other illegal acts, or does this illicit behavior have no further consequences?

There is no evidence to suggest that marihuana, or any drug, has a direct causal relationship with criminal behavior in a sense that its use invariably compels an individual to commit criminal acts. The relationship is more complex as the behavioral consequences depend upon the age and sex of the user, his mental state and associates, his socioeconomic status, and the extent of his involvement in and identification with drug abuse as a way of life. In the last instance, it is obviously a common thing to experiment with marihuana smoking once or twice and quite another thing to habitually use the drug, actively proselytize for initiates, or sell marihuana for a substantial profit.

Habitual use of marihuana is often associated with other illicit acts. First, many persons who are otherwise delinquent or criminal may also smoke marihuana. This, of course, does not suggest any causal relationship. Second, marihuana use is often pursued in a hedonistic peer group setting in which laws are violated. Again there is no causal relationship suggested. Third, use of more dangerous drugs is frequently preceded by the use of marihuana: the degree of causation here is also quite conjectural. On the other hand, use of marihuana is not necessarily associated with other illicit acts. Moreover, the extent to which occasional users go on to the use of more dangerous drugs or become involved in criminal activity is unknown.

A number of authorities have suggested that marihuana use in the United States is a type of behavior which is often associated with criminal activity. Other authorities hotly dispute this charge. Although most juvenile delinquents do not go on to become professional criminals, most professional criminals have been delinquents. The question remains, then, as to how many marihuana smokers are involved in a transitory episode of delinquency and how many become enmeshed and committed to a drug oriented way of life.

Because the acquisition of drugs and their possession are *ipso facto* crimes, all drug use is in one sense "criminogenic." With regard to other forms of criminal activity, however, there is no evidence that marihuana use has any crimongenic effects (with two exceptions which will be discussed below). The testimony which preceded the Marihuana Tax Act of 1937 included such lurid statements as:

> Under the influence of this drug [marihuana] the will is destroyed and all power of directing and controlling thought is lost. Inhibitions are relaxed. As a result of these effects, many violent crimes have been and are being committed by persons under the influence of this drug . . . I believe in some cases that one marihuana cigarette may develop a homicidal maniac probably to kill his brother [sic.].

Even at that time, responsible spokesmen for the medical profession objected to such statements feeling that there was no basis for them. Experimentation has proved that the objections were well founded. Marihuana has, a great majority of the time, an exactly opposite effect to the violence syndrome associated with urban crime. For the most part its users are passive, inactive, and lethargic.

We noted that there were exceptions to this rule. It is true that persons who need money for drugs sometimes turn to criminal activities such as burglary, purse-snatching, and prostitution in order to obtain enough. This is more true of hard-core narcotics and amphetamine abusers, because it does not take a great deal of money to support even a substantial marihuana habit. And because marihuana releases inhibitions, it *may* cause an apparently normal person to become violent, or a person from a culture where crime is endemic to join in criminal activity. The incidence of such effects is not known. But any drug, legal or illegal, which loosens self-control is likely to trigger such responses in susceptible persons. Persons who use marihuana deliberately in order to loosen their inhibitions about criminal behavior do so because it is available. Drugs such as alcohol, amphetamines and barbiturates are usually popular for this purpose. It may be that because marihuana is above all a mood intensifier, the person who *expects* to become violent after drug use will probably become so. The calmness and euphoria experienced by many of the current young users are a reflection of their search for a passive, non-competitive way of life.

Marihuana and Alcohol

Proponents of legalizing marihuana frequently make the claim that marihuana is less harmful to the individual and to society than alcohol.

At this point it is impossible to make a determination of the relative degrees of harm inherent in marihuana and alcohol—primarily because so very little is known about cannabis.

From the evidence that is available it appears that, from the standpoint of *physical* harm, cannabis is not as bad as alcohol. Psychologically they are equally capable of producing erratic behavior and dependence. Notwithstanding this fact, let us not forget that alcoholism afflicts more than five million people in the United States and it is one of our most enigmatic social problems. The wide-spread use and abuse of alcohol is a reality. While we cannot easily exchange existing folkways and mores concerning the consumption of alcohol, we may have a greater degree of freedom to wisely legislate policy on marihuana. The disastrous effects of alcohol have become a cultural reality in most of the world. No one will deny the tragedies that have been produced by overindulgence in alcohol. More than half of the tragic fatalities in the United States each year involve the drinking driver. Countless marriages and homes have been destroyed through this abuse. But granted the uncontestable truth of these facts, does it provide a valid reason for introducing yet another euphoriant into our society? The Commission is of the opinion that it very definitely does not.

Legalization of Marihuana

Throughout its series of hearings and numerous interviews conducted from coast to coast the Commission was exposed to virtually every position concerning the degrees of governmental control which should be imposed on cannabis. After months of deliberation the Commission concluded that the penalties prescribed by law have been too harsh. The cultivation, possession, or distribution of marihuana is illegal under the laws of all 50 states and the federal government. Many of these jurisdictions carry draconian punishments. In Minnesota, for example, earlier this year a youth was sentenced to life imprisonment for the possession of trace elements of marihuana in his pocket linings. Although the convicted individual has recently been paroled, the fact that such a sentence could be handed down is incredible in this so called enlightened era of legislative reality. In Michigan radical leader John Sinclair was given nine to ten years after handing two marihuana cigarettes, free, to an undercover narcotics agent.

Other investigative groups have received testimony concerning the monumental lack of wisdom inherent in many of the nation's marihuana laws. No less a person than the United States Surgeon General, Dr. Jesse Steinfeld, has concluded that laws against marihuana were first passed "with total disregard for the medical and scientific evidence about the properties of the drug or the effects." In testimony before the National Commission on Marijuana and Drug Abuse, Dr. Steinfeld noted, however, that marihuana cannot be given a "clean bill of health." Appearing at the Commission's two-day series of Chicago hearings, he suggested that "penalties for its use should be consistent with the danger and risk to the individual and society."

Governor Ogilvie also appeared at the same hearings on August 23, 1971. He described how the new Cannabis Control Act reduced penalties for marihuana violations in Illinois. He also pointed out that the thrust of legislation and law enforcement in this State is "aimed at the pushers, not at the drug users, who could be exploited as easy targets for arrest and conviction." The Governor also noted that notwithstanding the reduction in penalties, he is convinced that a case has not been made for the legalization of marihuana.

The Commission was impressed with the sincerity (although not necessarily the logic) in the arguments expounded by such champions of marihuana legalization as Professor of Sociology Alfred R. Lindesmith of Indiana University and Professor of Law John Kaplan of Stanford University. Both individuals have written widely read books calling for the legalization of marihuana.

Lindesmith, in his book, *The Addict and the Law,* takes the approach that we are operating a dual system of justice in the United States by legalizing alcohol and prohibiting marihuana. Lindesmith urges legalization of cannabis even though he admits that, "It is also undeniable that marihuana intoxication may sometimes lead to automobile accidents or to irresponsible or criminal acts." As stated above the Commission rejected the view that alcohol constitutes a *greater* social danger than marihuana or that the general comparison of alcohol and marihuana is meaningful and logically compelling. In the Commission's opinion it is invalid to justify the adoption of a new vice by trying to show that it is no worse than a presently existing one.

Kaplan takes a somewhat different approach in his book entitled *Marihuana — The New Pro-*

hibition. Kaplan contends that if there are any benefits to marihuana laws — and he can discern few — they are far outweighed by the damage they have done to American society. The current approach, Kaplan argues, ties up police and courts in a hopeless enforcement effort, turns a large segment of the younger generation at least technically into criminals, breeds disrespect for the law, spreads suppression between parents and children, encourages disbelief of warnings about the dangers of more dangerous drugs and forces marihuana smokers into contact with underground drug peddlers who frequently tempt them with far more hazardous wares.

The Commission found more than a grain of truth in the criticisms voiced by Kaplan. However, we could not abide by his radical solution of totally legalizing marihuana. We concluded that the "cure" to overly harsh marihuana laws should be reason and reality rather than surrender and open armed welcome of an exceedingly dangerous drug of abuse.

This Commission has attempted to keep an open mind as to the evidence which has been received in the course of many hearings, interviews, and thousands of hours of research and investigation on this critical subject. We and the public are still learning about the amount of harm which marihuana may be doing to those who use it. We tried to distinguish between the true, the false, the fact, and the opinion.

It is apparent that this problem will not be solved by extremists. Those who contend that drug use is a sympton of the degeneracy of our youth and who wildly proclaim that such moral depravity must be "stamped out" contribute very little to a solution. Similarly, those who advocate permissiveness do not fully consider the probable human wreckage which would result from legalization of cannabis. There is little to commend those who advocate the use and extol the virtues of marihuana.

Certainly, repressive and punitive laws cannot be defended as the solution to the marihuana problem. It destroys our criminal justice system to have penal statutes that are not uniformly enforced — and perhaps in some instances are unenforceable. Our Commission received many general statements of harsh and oppressive prison sentences that had been meted out to marihuana users or possessors. Many lamented that our laws were "making criminals out of our youth." In general, we found that the facts did not support these statements. We observed that the penalties for marihuana possession or even for selling are generally not imposed and that prison sentences are the rare exception rather than the rule.

The Commission was highly displeased with this situation: not because we disapprove of any judicial leniency but because this provided further evidence that the existing marihuana laws in Illinois were thoroughly unworkable and unrealistic.

For this reason our approach to marihuana legislation was, in our view, one of moderation and reality. We felt that what was needed was a realignment of penalties and a broad approach to the problem which would give judges and prosecutors broader discretion in adjusting society's response to marihuana. It was this spirit which guided the drafting of the new Illinois Cannabis Control Act. We believe it is the most realistic legislative approach to the marihuana problem. We do not for a moment believe that this law will be the final comment on cannabis. We do, however, believe that it is the most judicious response possible in these times of uncertainty which surround marihuana and those who use it.

Chapter 5
NARCOTICS

Introduction

The term "narcotic" generally refers to opium and drugs made from opium, such as heroin, codeine, and morphine. These drugs are distilled from the juice of the base of the white poppy flower and refined into some of the most valuable medicines known to man, but also some of the most abused drugs in the world. In addition, other drugs have been included under federal and state laws as "narcotics" which are pharmacologically entirely different from the opium derivatives. An example of this is cocaine, which is derived from the coca leaf and acts as a stimulant to the central nervous system. In addition, there are a number of classified as narcotic drugs under federal and state laws.

In this chapter we will deal only with those drugs which are true narcotics in the pharmacological sense. Other drugs which do not bear narcotic characteristics are discussed elsewhere in this Report.

History

The story of the opium poppy is nearly as old as the history of civilization. As long ago as 3000 B.C., in the ancient kingdom of Sumeria (now Iraq), man first discovered that the juice of the white poppy *(Papaver somniferum)* was useful in the control of dysentery. The ancients, appreciative of this medicinal remedy, spread knowledge of the white poppy east to Persia and west to Egypt where it was in common use by 1500 B.C. During the Greco-Roman period, opium was an ecnomically and medically important drug, used for its sleep-inducing and pain-relieving (analgesic) properties. By the beginning of the Christian era, its use as a medicament had spread to other parts of Europe. It was administered for cough and diarrhea, as well as to reduce pain and induce sleep. In Renaissance Europe, opium also was used to treat hysteria, thus becoming one of the first therapeutic agents for a mental disorder. The Portuguese, noted for their seagoing expeditions, carried the plant to India, which is

now the world's largest opium producer. Tenth century Arab traders brought the plant to China.

Opium has also been used since the earliest times as an agent of indulgence. Opium has the power to allay anxiety, gloom and despair, as well as to provide escape from boredom and loneliness — even from reality itself. There is an apparent reference to opium smoking in Homer's *Odyssey,* written in the 9th century B.C. Rouse's translation tells of "a drug potent against pain and quarrels and charged with the forgetfulness of all trouble; whoever drank this mingled in the bowl, not one tear would he let fall the whole day long, not if mother and father should die, not if they should slay a brother or a dear son before his face and he should see it with his own eyes." A related reference can be found in Homer's *Iliad* where the cup of Helen is described as "inducing the sense of evil." A Sumerian tablet describes an herb which is thought to be the opium poppy as "the joy plant."

Opium abuse first became widespread in India, where the Brahmin priests forbade the use of alcohol and the people turned to smoking opium for its euphoric effect. By the 16th century the opium poppy was being cultivated in China for purposes of trade, and its large scale use was reported by the Portuguese in the early 17th century. The Western introduction of tobacco smoking in the 17th century led to the "traditional Chinese vice" of opium smoking.

This reference was used because China had become the first country to experience a major opium addiction problem. Despite anti-opium smoking edicts in effect in China in the 18th century, imports of opium into China continued to increase. The Chinese government's alarm was reflected in the severity of the penalties meted out for opium smoking. By 1796 the death penalty had been applied to any use of or traffic in opium.

In 1839, the Chinese emperor appointed an aggressive administrator named Commissioner Lin. The newly appointed Commissioner soon demanded the surrender of all opium stored on Western ships. To insure compliance Lin held all occidental ships in Canton. When the opium was surrendered, the detained passengers and crew members were released.

This bold new approach was a blow to Western prestige and profits and soon resulted in extreme international tension. One night a British sailor became involved in a brawl which resulted in the death of a Chinese native. The Chinese demanded the surrender of the seaman but the British refused. This refusal in turn precipitated the struggle known as the "Opium War" (1840-1842). The Chinese were defeated and the British under treaty secured an indemnity of six million dollars. The treaty also established what was to become the greatest port in the Far East — Hong Kong. Opium importation doubled and tripled, continuing until 1911, when the British and Chinese governments agreed to restrict trade from India as well as cultivation of the opium poppy in China.

Both as a medicine and as a drug of indulgence, however, opium use had spread throughout the world. In America, the problem of opium addiction had begun before the founding of the Republic. By the 18th century, opium was known in the American colonies where it was used by physicians as a therapeutic agent. In the latter part of the 18th century, doctors recommended opium as a pain reliever in venereal disease, cancer, gallstones and dysentery. Its use was also advocated for relief of simple diarrhea, vomiting, spasms accompanying tetanus, and the pains of menstruation and childbirth. It was also used as a topical agent—applied to the abdomen to relieve stomach aches or to the cheek for relief of toothache.

Despite its wide medical use, opium's addictive liability was not understood by the medical profession. Opium smoking, and opium addiction, grew considerably in the United States during the 19th century as large numbers of orientals immigrated into this country to work on the great canal and railroad projects and to fill the demand for unskilled labor caused by the Civil War.

Opium eating, described as very common among the lower and middle classes, became a growing habit in America. It undoubtedly was stimulated in part by the semifictional accounts of the experiences of addicts. The most notable example of these accounts were the popular writings of Thomas de Quincy's "Confessions of an Opium Eater" published in the *London* magazine for the first time in 1821. In 1842, the American *Knickerbocker* magazine carried a similar article entitled "An Opium Eater in America" written by a young English immigrant named William Blair. The publication of the ecstatic and lurid details soon enhanced fascination with the powers of opiates among the addiction-prone segment of the population.

The problems of addiction arising from the spread of opium were compounded in the

1800's by the discovery of two opium alkaloids, morphine (1805) and codeine (1832). The properties of these drugs, like those of their parent, were imperfectly understood. Consequently, morphine and codeine were administered to cure the opium habit — with the result that opium addicts were merely transferred from one addicting drug to another. Because of its high potency morphine became increasingly popular among opium users. One grain of morphine produces about the same effect as ten grains of opium.

An even greater factor influencing the spread of narcotic addiction was the invention, in 1843, of the hypodermic needle. Brought to this country in 1856, it was used widely during the Civil War to administer morphine, not only to the battle-wounded, but also to those suffering from dysentery. The use of morphine was so widespread that one of the effects of the war was the creation of a large population of ex-soldier morphine addicts. In fact, the relation between Army service and morphine addiction was seen as so close that morphine addiction became known as "soldier's disease."

The final link in the opiate chain was forged in 1874 when scientists discovered how to chemically modify morphine into diacetylmorphine, commonly known as heroin. There was little interest in the new drug until 1890, when incredibly, it was produced as a cure for morphine addiction. The naive myth that heroin could cure morphine addiction exploded in 1900 when it was finally realized that heroin was even more addictive than morphine. According to some sources, heroin created addicts by the thousands. Equally important, heroin firmly established the hypodermic needle as the instrument of drug abuse.

Drug addiction in America was well established by 1900. It has been estimated that in the year that marked the beginning of the present century, one American out of every 400 was addicted to an opiate. Thus, we began this century with almost 190,000 American drug addicts, a figure which nearly matches many estimates of the number of heroin addicts in the United States today.

The response to this deadly problem was, in many ways, similar to that of government officials today. Since opium is not grown in any significant quantities in this country, the American government sought the cooperation of foreign powers to halt the flow of the drug into the United States.

In 1909, the International Opium Commission met in Shanghai to discuss the possibilities of effecting international agreements aimed at restricting trade in narcotic drugs to the scientific and medical communities. Since that time, governments have continued in their attempts to effect such restriction. Failure to achieve the laudatory objectives set forth at the Shanghai Commission need not be elaborated upon, since the evidence of failure is so dramatically portrayed in every major city of our nation.

It is interesting to note that although 14 nations were invited to participate in the Shanghai Commission, one nation, Turkey, failed to send a representative. Turkey's failure to offer full cooperation in international narcotic control has continued down to the present. The latest example can be seen in its refusal to accept a United States offer of $5 million to destroy its current $3 million opium poppy crop. A comparable attempt by the State of New York to lease the poppy farm lands and buy up the 1971 crop similarly met with failure. New York's Joint Legislative Committee on Crime, which spearheaded the effort, received technical advice and testimony from this Commission's Executive Director Charles Siragusa. Forceful tactics, such as cutting off financial aid, have not been used since Turkey is an important member of the North Atlantic Treaty Organization and a principal factor in the balance of power in the Middle East. Turkey's bilateral agreement to ban opium production after 1972 is discussed below.

The first federal attempt to control opium use came in 1909 with an act that prohibited the importation of opium, its preparations, and derivatives except for medical purposes. By 1912 many cities and every state but one had laws governing the prescribing and selling of opiates. In practice, however, these state and local laws were not vigorously enforced. Consequently, there was virtually no limitation on domestic sales of narcotics.

The next significant international effort to further the aims set forth at Shanghai was held at The Hague in December, 1911. The participants at The Hague Convention agreed that governments should control production, manufacture, and distribution of narcotics both nationally and internationally. It was further agreed that the production, manufacture, and distribution of opiate drugs would be limited to medical and legitimate uses only. Participants also agreed to "examine the possibility of making possession of controlled drugs a crime."

A young addict goes into a stupor after an injection of heroin.

The agreements reached at The Hague were later embodied in the Harrison Act signed by President Wilson on December 17, 1914. The Act was also the product of growing public concern over the magnitude of the narcotics problem and a realization that state and local laws were inadequate. Significantly, the Act did not make addiction illegal but sought to control the production, manufacture and distribution of narcotic drugs. The law required registration and payment of an occupational tax by all persons dealing with narcotic drugs. It further specified that only physicians could dispense narcotics, and that pharmacists could sell such drugs only on written prescription.

The Harrison Act failed to stem addiction, and crimes related to addiction continued to multiply. Since legitimate sources of drugs were totally unavailable to addicts, they turned instead to smuggled drugs. By 1920 narcotics control had been clearly characterized as a "law enforcement problem."

The reason why narcotic addiction gradually became a law enforcement problem rather than a purely medical concern can be traced, in part, to the Harrison Act. Because of the mood of the time, several court decisions subsequent to passage of the Act had the effect of stringently limiting the role of physicians in prescribing narcotics to addicts. These decisions permitted physicians to dispense drugs to addicts in diminishing quantities to break drug habits, but not in quantities sufficient to maintain such habits. This legal distinction, plus overprescribing by some doctors, led to a number of physician arrests and convictions. Such legal problems, added to the near medical impossibility of treating addicts on an outpatient basis, soon caused doctors to stop treating addiction.

Several clinical attempts to treat addiction were, however, made during this period. Some of the responses of the early 20th century have been resurrected recently. Just as Great Britain in 1968 opened clinics to dispense free heroin to addicts, in 1919 morphine clinics were opened in large cities in the United States. The concept practiced by these clinics was to provide free morphine to those addicted to it in an attempt to control their addiction and antisocial behavior. Instead, addicts living in suburban and rural areas flocked to the cities to obtain the free drug. Petty crimes in metropolitan areas increased rather than decreased.

In addition to the urban movements of addicts and the crime increase there were also allegations that the clinics were handing out drugs too freely, thus spreading addiction rather than curtailing it. Each of these factors led to the closing of these facilities by the federal

government in 1923. Approximately 40 such clinics were closed in that year.

Cut off from both legal drugs and clinical assistance, addicts unable to break their habits turned entirely to an underworld market that had only been a minor source of supply previously. Because of this tremendous demand, and because of the high profits involved, the spectre of organized crime was soon present. Illicit narcotic supply lines expanded and became more entrenched. Originating in various Asian and South American countries, millions of dollars worth of narcotics began to flow into the United States. (For a more complete analysis of these illicit traffic routes, see the discussion in Chapter 10).

In response to this proliferation of narcotics, in 1934 the United States Government established the Federal Bureau of Narcotics. State and local law enforcement agencies followed this move by creating special narcotic units within their investigative divisions.

As the illegal traffic burgeoned, narcotics officials found that, in order to crush the traffic, it was necessary to apprehend addicts (often sources of supply) as well as non-addict pushers. In addition to arrests, federal authorities soon realized the importance of rehabilitation as an ancillary method of reducing the demand for narcotics. Accordingly, Congress, in 1929, authorized construction of special high-security addiction treatment facilities at Lexington, Kentucky, and at Fort Worth, Texas. By World War II, international treaties, vigorous law enforcement, and expanded drug abuse education were credited with a reduction in the number of known addicts in the United States to less than 60,000 individuals. This was probably the lowest ebb of addiction during this century.

After World War II, "soldier's disease" was again a problem. Additionally, rapidly rising arrest rates disclosed that increasing numbers of younger people were becoming involved with narcotics. The reaction was to call for more stringent controls. Congress and state legislatures complied by increasing penalties for narcotic offenses. In 1946 the Harrison Act was amended to include synthetic narcotics which had been developed during the War. In 1951 the Boggs Amendment introduced minimum mandatory sentences for all narcotic drug (and marihuana) offenses and prohibited the suspension of sentences and probation for subsequent offenders. In 1956 the Narcotic Drug Control Act raised the minimum mandatory sentences for narcotic violations. For example, the minimum mandatory penalty for a first violation of the Harrison Act (for illegal sale) was raised to five years with no possibility of probation or parole. In all other categories, with the exception of first offenders for possession only, the Act prohibited suspension of sentences, probation and parole.

The Harrison Act along with the above amendments and others remained the basic federal drug statute until 1970, when Congress passed the Drug Abuse Prevention and Control Act. This Act, along with major revisions of Illinois law, have been discussed previously in Chapter 1 of this Report.

During the years following The Hague Convention of 1911 there were several additional international conferences, with the United States representatives taking leading roles in drafting and passing multilateral treaties. These conferences explored the legal production of natural and manufactured narcotic drugs, the legal international commerce, the illicit traffic, addiction and many other areas. The more significant of these conferences related to the limitation of the legal production of opium to that required for the world's medical and scientific needs, and the similar control of cocaine and the synthetic narcotics.

The Single Convention of 1961, which was ratified by the United States, eventually codified these and prior conventions, treaties and protocols. Its more important provisions retained international limitations and controls, including opium from which is derived the heorin that currently plagues this country.

At the same time that stiffer penalties were being set the view of the addict as a sick person began to have greater impact on popular opinion. This view was reinforced by sympathetic — if somewhat inaccurate — portrayals of addicts on television, in films, in books and magazines, and on the stage. In contrast to the accustomed view of the addict as a vicious criminal, these presentations showed the addict as a tortured human being, desperately in need of help. This growing public understanding continues today. The "heroin pusher" was once thought of as the lowest form of humanity extant in society. Today many people realize that he may very well be the teenage boy next door.

A further impetus to a changing attitude among some segments of the population came with the White House Conference on Narcotics and Drug Abuse in 1962. The issue of whether

the addict was a sick person or a criminal was a central theme at the Conference. In its report to the Conference delegates, the Ad Hoc Panel on Narcotic Addiction and Drug Abuse referred to the addict as "an inadequate personality . . . unable to cope with the stresses of normal life." From the debates and comments which followed the Conference, a new consensus emerged: The addict is a sick person, as well as a criminal. Out of the Conference also came heightened interest in the need for treatment programs for addicts. A number of state, municipal and nongovernmental programs were undertaken in various parts of the country. A discussion of treatment modalities and rehabilitation issues follows in Chapter 9.

Of all the narcotic alkaloids heroin is today the most deadly problem in the United States and other countries. As previously noted heroin is derived from opium. Opium is legally produced in only seven countries, for export to those countries, including the United States, where derivatives used in medical science are manufactured into legitimate products such as morphine, codeine and others. However, because of excessive opium production in those seven countries and clandestine opium production there and in other countries, heroin is also produced illegally. This is the source for the estimated 300,000 heroin addicts in this country. A tragic percentage of these is composed of our youth — our hope for tomorrow. The "soldier's disease" of the past decades remains with us: the only difference being that it has taken on a far more ugly form — that of *intentional* heroin addiction. It is estimated that as many as 60,000 American troops in Vietnam may be addicted to an extraordinarily pure form of heroin.

President Nixon, in a recent address before the House of Delegates of the American Medical Association, characterized heroin addiction as "America's Public Enemy No. 1." He went on to say that, "It is the greatest of all present threats to our social fabric. Spreading like a plague throughout our society, the drug menace erodes our nation's strength and destroys our nation's spirit. Worst of all, it threatens to undermine our nation's future."

At this juncture in history a massive mobilization of effort has begun to fight narcotic addiction. The Federal Bureau of Narcotics and Dangerous Drugs has increased its operations several fold during the past decade and now spans the globe. Its efforts are supplemented by an army of state and local law enforcement officers across the country. Federal funds from the Law Enforcement Assistance Administration are disbursed across the nation for needy and innovative programs. Bold new laws are being passed designed to crush the illicit traffic and cure addiction. Treatment and education programs continue to expand as more research becomes available. The federal government recently established a multimillion dollar drug program to get at the sources of drug abuse and to rehabilitate drug abusers. To head the agency President Nixon named Dr. Jerome Jaffe of the University of Chicago and former head of the Illinois Drug Abuse Program.

Perhaps the federal government's most notable achievement thus far has been the securement of Turkey's bilateral decision to halt opium poppy production after harvesting the 1972 crop. This decision was announced by Turkey's Prime Minister in Washington, D.C. on June 30, 1971. In attendance at the announcement were President Nixon and Secretary of State Rogers.

In return for Turkey's promise to ban poppy production, the United States has pledged financial and technical assistance in helping Turkey to find an alternate cash crop. Turkey also promised to be much more diligent in overseeing the collection of this year's poppy harvest in order to protect against diversion. The President has promised American assistance in assuring Turkey's fastidiousness in this regard. This bilateral agreement will be discussed in more detail later in this Chapter.

This mobilization is nothing more than a start, albeit an impressive one. Much remains to be done. America has begun to understand the plight of the addict and the monstrous horrors of heroin.

Pharmacology

Natural and synthetic morphine-like drugs are the most effective pain relievers known to man. They are among the most valuable drugs available to physicians and are widely used for short-term acute pain resulting from surgery, fractures, burns and other injuries as

well as to reduce suffering in the later stages of terminal illnesses such as cancer. These agents are also used for diarrhea, coughs, and other therapeutic conditions. In fact, morphine is used as the standard of pain relief by which other narcotic drugs are evaluated.

Medically defined, "narcoticfi drugs" are those which produce insensibility or stupor because of their depressant effects on the central nervous system. They produce a marked reduction in sensitivity to pain (analgesia), create drowsiness, induce sleep, produce mood changes, and reduce physical activity. Side effects can include nausea and vomiting, constipation, itching, flushing, constriction of the pupils, and respiratory depression. The most serious side effect of narcotics is the fact that they are all addicting in both a physical and psychological sense.

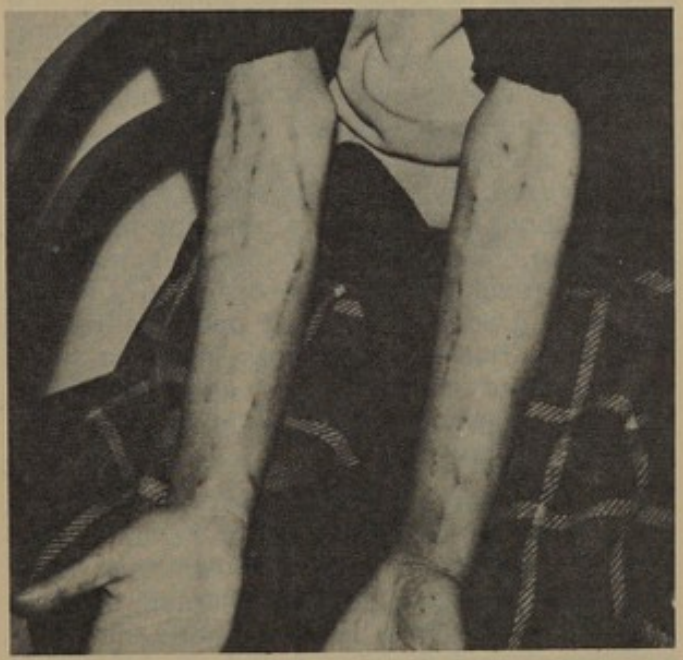
This addictive quality makes them less than ideal analgesics for prolonged treatment periods.

Opium is the dried latex from the unripe seed capsule of *Papaver somniferum*, a poppy indigenous to Asia Minor. Alkaloids are the pharmacologically active constituents of opium. Although there are many opium alkaloids only morphine, codeine and papaverine (smooth muscle relaxants) are widely used clinically. Morphine, the most important alkaloid, is found in the highest concentration in opium and has a main activity that is attributable to its effect on the central nervous system. In humans, it exerts a narcotic action typically manifested by analgesic drowsiness, mood changes, and mental cloudiness. A significant feature of the analgesic is that it occurs before and often without sleep. Morphine will alleviate pain in part because the drug blocks the ability of the brain to "recognize" some levels of pain. When small to moderate amounts of morphine are given to patients experiencing pain, discomfort, worry, tension, or other complaints, euphoria is frequently experienced as a result of the relief obtained.

In contrast, when morphine in the same dose is given to a presumably normal pain-free individual, the experience is not always a pleasant one. Sometimes dysphoria rather than euphoria results, consisting of mild anxiety or fear. Frequently there is nausea and occasionally vomiting. Morphine also produces mental clouding characterized by drowsiness and inability to concentrate, apathy, lethargy, reduced physical activity, and reduced visual acuity. If the external situation is favorable, sleep may ensue and dreams may be prominent. The psychological effects outlast the analgesic action by many hours. Also, since morphine has a physical dependence liability, it is not generally used therapeutically for mood alteration although it is still an effective tranquilizer.

Addiction

As indicated previously opiate type drugs produce addiction. This is produced by the drugs' chronic toxicity. The physical and psychological dependence produced by a given drug requires continuation of that drug or else a serious physical and mental derangement will result. The body will require repeated and larger doses of the drug. Once the habit starts, larger and larger doses are required to get the same effects. This happens because the body develops a tolerance for the drug.



"Tracks" are left from regular use of narcotics injected into veins.

The typical characteristics of this type of addiction include:

1. *Tolerance:* increased doses are needed to obtain the desired effects.
2. *Habituation*: psychic dependence; the patient has the impression that he must take the drug and that there is some

benefit derived from it. This type of habit can be very strong and difficult to break. Withdrawal symptoms can also occur before physical dependence occurs.

3. *Physical dependence*: alteration of the cells of the body from normal; in this altered form the presence of the drug is necessary for continued function. The drug almost becomes a cell nutrient without which they cannot perform or function normally.

When addiction develops and the drug supply of narcotic analgesics is cut off, characteristic symptoms of withdrawal may develop. They are typical of any drug addiction and include: restlessness, irritability, shivering, muscular tremors, nervousness, anxiety, yawning, running eyes and nose, severe aches in back and leg muscles, increase in breathing rate, blood pressure and temperature, headache, flushing of the skin, chills, mydriasis (prolonged or excessive dilation of the pupil of the eye), insomnia, abdominal cramps, excess sweating, delirium, more severe muscular tremors (approaching convulsions), vomiting and diarrhea (over several days leading to dehydration and weight loss), and finally, a feeling of desperation and an obsessing desire to secure a "fix." The intensity of the withdrawal symptoms varies with the degree of physical dependence. This, in turn, is limited to the amount of drug customarily used. Typically, the onset of symptoms occurs about 8 to 12 hours after the last dose was taken. Thereafter, symptoms increase in intenstiy, reach a peak between 36 to 72 hours, and then gradually diminish over the next 5 to 10 days. However, weakness, insomnia, nervousness, and muscle aches and pains may persist for several weeks. In extreme cases, death may result.

Most treatment authorities have reported that the withdrawal symptoms observed in today's addicts are substantially less virulent than those observed a decade ago. Carl Charnett, Director of Chicago's Gateway House, reports that most withdrawals experienced today are no worse than "a bad case of the flu." The reason for this reduction in intensity is attributable to the lessening percentages of opiates contained in the drugs sold in the United States today. In most cases the actual percentages of heroin in the drugs taken is usually between two and five per cent. This is far below the levels experienced during the 1950's and early 1960's. Parenthetically it is worth mentioning that the purity of heroin being taken by American soldiers in Viet Nam is many times higher than that found in the United States. In many cases the heroin may be as much as 83 per cent pure. This represents as pure a form of heroin as can be obtained anywhere in the world. One is properly alarmed over the horrors of withdrawal experienced by those soldiers who choose to "kick the habit."

Simply stated the evolution of heroin usage involves three stages. In the beginning, the user occasionally injects a small dose of heroin for one or more of several previously cited reasons. The person is referred to as a "chippy shooter" or a "joy popper." The user then gravitates to the next stage when he increases the frequency of injection and the dosage amount. At the point where one or more characteristics of the withdrawal syndrome are experienced, the user becomes "hooked," he must take heroin injections to eliminate the withdrawal symptoms and return to "normalcy". He is now an addict and no longer a user.

Types of Narcotics

The oriental poppy plant from which opium is obtained must be cultivated. The plant requires rigidly controlled soil and climatic conditions such as those in Turkey, Iran, Egypt, and India. Most of the opium is cultivated in Asia Minor and it is used as the source of morphine and the other opium alkaloids.

In addition to the naturally occuring opium alkaloids there are several morphine derivatives which are often referred to as synthetic opium alkaloids. Their principle pharmacological use is for the relief of pain, and most of the statements discussed previously under the Pharmacology Section of this chapter will generally hold true for most of these agents.

In general, all of the addictive analgesics can be divided into three categories, as follows:

1. Natural opium alkaloids
   A. Morphine
   B. Codeine
2. Synthetic derivatives of opium
   A. Diacetylmorphine (heroin)
   B. Dihydromorphinone
   C. Oxycodone
3. Synthetic opiate-like drugs
   A. Meperidine
   B. Methadone
   C. Anileridine
   D. Alphaprodine

Morphine has been used extensively for many years and is still the most important narcotic analgesic. However, it takes a second

place to heroin as a drug of abuse. Still, morphine is widely used by addicts particularly when heroin is difficult to obtain. Euphoria can be produced with small doses and tolerance builds rapidly.

Codeine, or methylmorphine, is a very important analgesic and antitussive drug. In therapeutic doses, it is less sedating and analgesic than morphine. Tolerance to codeine develops more slowly and it is less addicting than morphine. It is less potent in terms of inducing euphoria. When withdrawal symptoms occur, they are less severe than with most potent drugs. It is commonly abused in the form of exempt narcotic cough preparations.

Heroin, or diacetylmorphine, is a highly euphoric and analgesic drug. It is much preferred by the addict, who will take it intravenously. Because of its great addiction liability, heroin is not used for medical purposes in the United States and may not be legally manufactured in or imported into this country.

Heroin produces an intense euphoria making it the most popularly abused narcotic. Similar to all narcotic drugs, a tolerance develops and the abuser must ingest increasingly larger quantities to get his "kicks." The tolerance to heroin and other narcotics can be so highly developed that the amount of drug an addict can take is limited only by the difficulty he has in dissolving it and injecting the large volume of solvent he requires.

Heroin is synthesized from morphine. Grain for grain it is up to ten times more potent in its psychological effects. Pure heroin is "cut" or diluted by the trafficker with substances like milk sugar or quinine or both. By the time the drug is sold to the addict, the heroin content usually ranges from two to five per cent and rarely over ten per cent.

Heroin, which is usually mixed into a liquid solution and injected into a vein, appears to dull the edges of reality. Addicts have reported that heroin "makes my troubles roll off my mind" and "makes me feel more sure of myself."

The drug depresses certain areas of the brain and may reduce hunger, thirst, and the sex drive. In general, many factors influence the effects of the drug. These include the user's personality, the size and frequency of dose, and how the drug is taken. Hydromorphone (dihydromorphinone) is up to ten times as potent an analgesic as morphine. Its respiratory depressant effect is correspondingly greater than morphine although it may be less nauseating and constipating and is as addicting as morphine. Usually it is given by injection. Like morphine, it is the next choice after heroin. Although almost as potent as heroin, the drug does not appear to have the thrill associated with intravenously injected heroin.

Oxycodone (dihydrohydroxycodeinone) is a synthetic derivative of opium. This substance has recently been classified as a drug with high addiction potential. Although effective orally, most addicts dissolve tablets in water, filter out the insoluble binders and "mainline" the active drug.

Meperidine is a synthetic opiate-like drug used as an analgesic. The drug may be slightly less sedating than morphine and is definitely addictive. Meperidine was claimed to be without addicting potential when first produced. Experience, however, proved otherwise (as it did with morphine and heroin). Addiction is slower to develop and less intense than with morphine.

Methadone was discovered by the Germans during World War II. Although the structural formula of methadone does not obviously resemble that of morphine, its analgesic potency and other effects are quite similar. Development of tolerance and addiction to methadone are known to occur but may be slower than that following the use of morphine. Methadone has been used as a treatment drug in the rehabilitation of narcotic addicts. (See Chapter 9 of this Report.)

Abuse

The abuse of narcotic drugs dates from ancient times. The appeal of morphine-like drugs lies in their ability to reduce sensitivity to both psychological and physical stimuli and to produce a sense of euphoria. They dull fear, tension, and anxiety. Under the influence of narcotics, the addict is usually lethargic and indifferent to his environment and personal situation.

Chronic use leads to both physical and psychological dependence. Tolerance develops and ever-increasing doses are required in order to achieve the desired effect. As the need for the drug increases, the addict's activities become increasingly drug-centered. As noted by Howard Becker in his book *The Outsiders* the drug addict usually realizes his complete slavery to narcotics when virtually everyone in his circle of friends and acquaintances is similarly drug dependent.

Addicts live under the perpetual threat of an overdose. This can happen in several ways. An addict may miscalculate the strength of his dose or the drug may be stronger than it was reported to be at the time the addict bought it. Addicts sometimes fail to recognize the tolerance factor associated with narcotic abuse. Sometimes an addict will revert to narcotic abuse after undergoing withdrawal. Having failed to allow for his loss of tolerance he injects a dosage greater than his body can stand and kills himself. Death from narcotic overdosage is caused by respiratory depression.

There have been recorded cases of addicts who died from injections of poison, usually a rat exterminant substance, mixed in with heroin, sold to persons suspected of being police informers. These "hot shot" cases are usually characterized as heroin overdoses when in truth the cause of death was poison. In some instances the police establish that murder was committed if specific toxicologic tests are conducted to determine the presence of poison. However, where murder is not suspected, toxicologic tests are only performed for the detection of narcotics.

An addict injects heroin into his veins.

Although the possibility of death from an overdose of narcotics is an ever constant danger to the addict, the harmful effects are usually indirect. Because addicts do not feel hungry, they often suffer from malnutrition and vitamin deficiency. Because they are preoccupied with drug taking, addicts usually neglect themselves. They are more apt to contract infections because their nutritional status is poor and because they may inject contaminated drugs intravenously and are likely to be using poor or unsterile injection techniques. This may result in serious or fatal septicemia (blood poisoning), hepatitis, and abscesses of the liver, brain and lungs. Because of the analgesic qualities of narcotics, addicts are frequently unaware of extremely painful conditions such as advanced tooth decay and appendicitis.

In the beginning, heroin and other narcotics are generally taken intermitantly rather than continuously. Younger users may begin on an occasional weekend on "spree" basis. These individuals are sometimes called "joy-poppers," or they are said to have a "weekend" habit. Use at this stage is often casual and infrequent. The heroin may be taken by subcutaneous injection ("skinpopping"), or by sniffing ("snorting" or "horning"). Later, as the user's tolerance increases, heroin is injected directly into the blood stream ("mainlining"), the habit grows and with it the cost to satisfy the habit also increases to an expense of $50 to $100 a day, or more.

When the drug is first taken it induces a characteristic group of signs and symptoms. A few seconds after the injection, the addict's face flushes, his pupils constrict, and he feels a tingling sensation, particularly in the abdomen, which addicts say resembles a sexual orgasm. Tingling gives way to a state of euphoria. Later on, he goes on the nod, that is, he drifts off into a somnolent state waking up and then drifting off again, and all the while indulging in daydreams. The effects of the drug wear off in approximately four hours. While the user is on the drug, he is generally disinterested in any activities.

Much has been written about the equipment that the drug addict uses. The "outfit" or "artillery" (See Glossary for additional terms) used by the addict for taking an injection or "fix" consists, in general, of a number of readily available materials such as:

A teaspoon with bent handle	a—for dissolving the drug
Matches	—to heat the drug and aid in its dissolution

A medicine dropper	—for use as a syringe
A hypodermic needle, razor blade, nail, or safety pin	—any of which may be used to "shoot" directly into the blood stream
A piece of cotton	—to filter the drug
A rag or length of rubber tubing	—for use as a tourniquet in order to find the vein for injection.

The dangers in using this "outfit" are obvious. The first is that the strength of the heroin being injected into the blood stream is unknown. It may be significantly stronger than that to which the body is accustomed and the user may suffer a violent reaction. As indicated previously in this Report deaths from overdoses (OD's) are becoming increasingly frequent.

In addition to the possibility of taking a lethal overdose, there are a number of other dangers. The substance being sold on the street may contain impurities that can cause blood poisoning. Infection at the site of injection is common, and the veins of the long-time addict may be punctuated with abscess scars. There have been many cases of transmission of viral hepatitis from one heroin user to another by sharing contaminated injection equipment.

Of greater concern to the addict than the possibility of contracting disease is the inevitability of scarred or sclerotic veins, i.e., veins whose walls have deteriorated from repeated puncturings and have left "tracks." In time, less accessible veins in other areas of the body must be exploited by the addict or, in case of a medical emergency, by a physician.

The Narcotic User

Studies by the United States Public Health Service show that heroin addiction today is found chiefly among young men of minority groups in ghetto areas. Estimates of the number of addicts in the United States range from 100,000 to 300,000. It is generally agreed that more than half live in New York State and most of these in New York City. Recent figures show that more than half of the addicts are under 30 years of age.

The average age for discovered addicts has dropped from 35 in 1950 to 23 today. In recent years heroin addiction has begun to spread to the college campus and the suburban home. An alarming number of white youths are beginning to use heroin as "just another drug." A modestly increasing ratio of whites are becoming addicted to narcotics. Approximately 51 per cent of all addicts today are white according to the Bureau of Narcotics and Dangerous Drugs. This compares with 44 per cent in 1959. Many young people who have become "strung out" on drugs have sought out heroin as the ultimate drug. Many who have grown accustomed to the placidity and euphoria of barbiturates and marihuana have begun using heroin on the presumption that its effects are similar, albeit more intense. Of course, one of the tragedies of our time is the wide spread heroin use which has sprung up among our soldiers in Viet Nam. The return of the 30,000 to 40,000 addicted troops to society may prove to be yet another tragic chapter of this unfortunate war.

Narcotic addiction in the United States is not limited to the heroin users. Some middle-aged and older people who take narcotic drugs regularly to relieve pain can also become addicted. So do some persons who get drugs easily, such as doctors, nurses, and druggists. Studies show that this type of addict has personality and emotional difficulties not much different from other narcotic abusers.

Many addicts admit that, once on drugs, getting a continued supply becomes the main object of their lives. Concentration on getting drugs frequently prevents the addict from continuing with his education or his job. His health is often bad. He may be sick one day from the effects of withdrawal and sick the next from an overdose. Statistics indicate that the life span of the drug-dependent individual may be drastically shortened. He usually experiences great difficulties with his family and is almost always in trouble with the law.

Some studies suggest that many of the known narcotic addicts have had some trouble with the law before they became addicted. Once addicted they may become even more involved with crime because it costs so much to support a heroin habit.

Most authorities agree that the addict's involvement with crime is not a direct effect of the drug itself, but turning to crime is usually the only way he has of getting the amount of money required to support a heavy habit. His crimes are nearly always thefts or other offenses against property. Rarely does he engage in crimes of passion or violence. In addition to thefts and other property crimes, female addicts very frequently turn to prostitution in order to procure their daily supply of narcotics.

The Heroin Crisis

Ten years ago heroin was regarded as a "loser's drug." It was said to have made helpless addicts out of thousands of ghetto Negroes, a few jazz musicians and a handful of show business types. For years the official figure was placed at 68,000 addicts, but neither the Federal Government nor any private agency knew if this estimate was accurate. At the time little attention was given to research into the number of addicts since heroin addiction was not regarded by most people as a national problem.

This is no longer the case. Heroin addiction by any standard has risen to the level of a national crisis above and beyond the crime and waste of human potential associated with heroin addiction. The stark fact is that many heroin addicts die as a result of drug abuse and most die young.

According to Dr. Milton Helpern, Chief Medical Examiner of the City of New York, at present, in New York City, narcotic addiction is the greatest single cause of death of adolescents and young adults from 15 to 35, exceeding deaths from any other single cause, accident, suicide, homicide, or natural disease.

As indicated above, the spectrum of drug addicts is widening. UCLA psychiatrist Dr. J. Thomas Ungerlieder says that since the heroin plague began "nice Jewish boys are coming out of the woodwork." The same might be said of Mormon children, Japanese Americans, and other exemplars of healthy, hard working middle class ideals.

For the first time in United States history doctors and public officials are speaking in near unison of a heroin emergency. According to Dr. Jerome H. Jaffe, former head of the Illinois Drug Abuse Program, now in charge of President Nixon's new Drug Control Program, the heroin epidemic has become a full-fledged crisis. "Heroin has exploded on us like an atomic bomb," says John Gianardi, President of the New Mexico Pharmaceutical Association.

This concern is growing among the American public. A recent Gallup poll showed that since March, 1971, "drug addiction" has risen from 7th to 3rd place on the public list of "most important" national problems. The prime symbol and expression of that concern can be seen in President Nixon's massive 370 million dollar program against the heroin menace. It has placed significant emphasis on addict "amnesty" and rehabilitation as well as the destruction of the illicit opium trade.

Explanations for the recent increase in heroin addiction vary widely. Psychiatrists, theologians, and sociologists theorize about family stress, spiritual weakness, and social unrest. Others have voiced suspicions of a growing campaign by forces of organized crime to create an American "market." Some radicals have argued that excessive enforcement activities against marihuana have caused many youths to turn to heroin. Many of the leading authorities espouse the view that heroin is simply a drug whose time had come for a variety of psychological and pharmacological reforms. In a recent *Newsweek* article an 18 year old Boston girl said that, "Junk is the farthest you can go. It is the king of drugs. Everyone else is into acid and speed. You know you can hit if you get into smack."

Dr. Donald B. Louria, President of the New York State Council on Drug Addiction and an advisor to this Commission, points out that heroin is the logical outgrowth of the "pot-and-acid" cultures. He suggested that it seems to be true enough that experimenting with drugs leads to further experimenting with drugs. But it is also true that most middle class parents out of ignorance or fear misinformed their children about the dangers of marihuana. According to Louria, many youths have erroneously concluded that "Pot is fun, and it's no big deal." Unfortunately, he added, after young persons discovered these "facts", they were in no mood to pay attention to the strikingly similar warnings they heard about heroin, true or not.

The drug culture led to widespread heroin abuse in a number of other ways. As the staff of San Francisco's Haight-Ashbury free clinic told the Commission, young people in the drug culture progressed logically from "pot to acid" and on to methedrine (or other "speed" drugs like methedrine). The speed drugs were used to relieve the anxiety of LSD. But, as the youths soon found out, speed had its own horrors—particularly the terrible "crash" that comes at the end of several days of sleepless, foodless hyperactivity. There is only one drug that will get the speed freak down to earth gently, and that is heroin. Thus, members and observers of the drug culture have come to speak of heroin as the "ultimate downer." Furthermore, methedrine and methamphetamine themselves are often taken by injection. Thus the youthful drug abuser is introduced to the use of

Turkish peasant women harvest crude opium from poppy plants.

syringes to obtain the effects of drugs. Once the fear of using needles and "hard drugs" is overcome, the transition to heroin is made much easier. Frequently, peer group pressure will play a substantial part in persuading large groups of students to "get up the nerve" to try heroin. After a few students have begun using heroin and do not exhibit any marked adverse effects, other students may wish to follow in their steps. According to Dr. Matthew P. Dumont, the head of drug rehabilitation for the Massachusetts Mental Health Department, "It may have been true two decades ago that skin color, social class, and family disruption provided correlations with drug addiction but it is not true today. Now it is openly and unashamedly a peer-group phenomenon."

Heroin Importation

At present, there are three principal routes used to bring pure heroin to the United States. These are comparable to the marked shipping routes used by the major lines.

The first and currently most important route for smuggling heroin into the United States is a pattern originating in the Middle East. The opium grown in this area, primarily Turkey, is transformed into morphine base and shipped from Turkey, often via Lebanon, to clandestine laboratories in France. In France, usually Marseilles, the morphine base is converted into heroin. Then it's smuggled via Madrid and Paris to New York, Miami, Mexico City, and Montreal for ultimate distribution in the United States. This smuggling route has been expanded in recent years to include an important link in Spain as a transshipment point. Germany has also become a key location in the illicit traffic of heroin because the influx of Turkish workers into that country to fill a demand for labor has provided an ideal smuggling network.

The second principal route centers in the Far East. Burma, Northern Thailand, and Laos are sources of opium which is shipped to Bangkok and Singapore for conversion to heroin. In the past, most of the heroin produced in the Far East was consumed by the large addict population in Hong Kong and elsewhere. In the past two years, however, increasingly significant quantities have been smuggled into the United States, sometimes via the Philippines and Canada.

The third route originates in Mexico where the opium poppy is grown in remote mountain areas and converted into heroin in clandestine laboratories located in isolated mountain areas and small villages. Because Mexican heroin is usually brown rather than white, like the Middle or Far East variety, its ultimate distribution points can be located. After being smuggled into the United States, the brown Mexican heroin is consumed in Chicago, Detroit, and other Midwestern cities, as well as the Southwest and far West.

To be used for its ultimate purpose, the juice of the opium poppy must be processed and chemically altered after the crop is harvested. When the poppy is ripe, the farmer makes an

incision on the pod containing the opium alkaloids. A gummy substance seeps out and is collected. This substance is the raw opium. Three acres of poppies will yield ten kilograms of opium. To reduce the size and make it easier to smuggle, opium is chemically reduced to morphine base, since ten kilograms of opium yield one kilogram of morphine base. The morphine base is the substance usually smuggled to the clandestine laboratories in Marseilles and other European countries, where about $700 worth of equipment will convert the kilograms of morphine base into one kilogram of heroin.

Informed sources estimate that about 80 per cent of all heroin reaching this country originates in Turkey. The growth of opium poppies is big business in Turkey both legally and illegally. There are between 70,000 and 100,000 Turkish farmers engaged in poppy growing. These farmers harvest two crops a year, one in May or early June, the other in the fall.

The growth of opium poppies is legal in Turkey, one of only seven countries in the world to sanction its growth for export. The other countries which permit the legal growth of opium poppies for export include Bulgaria, Greece, Yugoslavia, the Soviet Union, Iran, and India.

The Turkish Government controls the growth of opium poppies by deciding which provinces may plant the crop. Largely in response to pressure from the United States the Turks have cut down on the number of provinces where poppy growing is legal. But even the limited number of provinces presently permitted to grow opium poppies can produce a more than adequate supply of illicit heroin for the United States market. The individual farmers are not licensed to grow a prescribed number of acres of poppies, yet their total output is estimated and controlled and ultimately purchased by the government. Because of a lack of controls the government never knows how much opium was actually produced. Thus the crop purchased by the Turkish Government never represents the total production of opium. It is the excess opium production which finds its way into the illicit market. While the Government pays farmers about $16.00 a kilogram for the crude opium, the illicit trafficker will offer as much as $35 and $40 a kilogram. Obviously there is ample economic incentive for the Turkish farmer to make sure he grows enough opium to sell both to the Government and to the black marketeers.

During the past few years, Turkey has been progressively reducing the areas assigned to poppy cultivation with a view to concentrating her production of opium and improving the efficiency of control. Effective control by the Turkish Government has been virtually nonexistent until very recently. In 1955 the Turkish Government authorized cultivation of the opium poppies to be limited to 43,980 hectares (a Turkish land measurement equivalent to 2.471 acres). This cultivation yielded 221 tons of licit crude opium.

From 1955 to 1965, the Turkish Government reduced opium poppy cultivation to 22,300 hectares. In 1965, the quantity of opium produced legally was reduced to 86 tons. From 1965 to 1968, hectare reduction continued to decrease down to 13,000 hectares under cultivation by the end of 1968. The reduction of hectares was accomplished by reducing the number of provinces allowed to cultivate opium poppies.

The Turkish Government also reduced the number of farmers cultivating opium from 200,000 to approximately 80,000 within a ten-year period.

At one time, Turkey permitted farmers in 50 provinces to grow opium but this has been gradually reduced largely as a result of pressure by the United States. In 1969, the number of provinces where opium could be legally grown was down to nine, and in 1970, to seven provinces.

But despite these seemingly impressive figures the action of the Turkish Government has not materially reduced the amount of opium available on the black market. The four provinces where opium production will be permitted through 1972, for example, currently produce 90 per cent of Turkey's opium. In effect, to placate the United States, the Turkish Government weeded out the smaller opium producing provinces while permitting the larger opium farm areas to stay in business.

Perhaps the paramount problem in trying to get the Turks out of opium production has been political. Opium production has been an ancient and profitable occupation for Turk farmers and they have shown little desire to get out of the business. The Government, of course, has been sensitive to these pressures. The current Prime Minister, Suleyman Demorel, in fact, comes from the largest opium producing province in Turkey. Also, the Turks took the position that heroin abuse is an American problem, and, as such, should be solved by the United States without the assistance of Turkey. Few Turks, they point out, are addicted to heroin. But perhaps the most significant political consideration has been the feeling by the

Turks that they are lot "lackies" of the United States.

A national American magazine, in describing the opium situation in Turkey, recently alleged that graft and corruption have contributed to the diversion of legally produced opium into illicit channels.

Despite these difficulties the Nixon Administration continued to address itself vigorously to the goal of heroin eradication by cutting off Turkish opium production. As mentioned above, on June 30, 1971 the United States and Turkey announced an argeement whereby Turkey will halt planting of all opium poppies after the harvesting of the last crop in the middle of 1972. In return for this agreement the United States will provide money and technical assistance to help Turkey replace poppies with other cash crops. As yet, no commitment has been announced as to the specific amount of this financial aid.

Turkey has promised to continue its efforts toward stringent licensing and control of opium poppy production. It will also attempt to purchase as much as possible of opium produced through the last legal harvests, at premium prices, to prevent the opium from being diverted to illicit channels. In that same agreement Turkey also agreed to reduce its number of opium producing provinces from seven to four before the complete ban goes into effect after the last 1972 harvest.

The Chicago *Tribune* editorial of July 1, 1971, hailed this agreement as a major achievement but made some significant comments regarding our payment of money to Turkey:

> . . . While we welcome the results of this deal, we are less enthusiastic about the means employed. In offering to pay Turkey for not growing poppies, the American government is exporting a domestic policy of paying farmers billions of dollars for not growing certain crops as a means of supplementing farm income while controlling supplies. This Spring Washington added a variant of this policy thru a small pilot program to pay farmers not to grow wild marihuana. Paying farmers not to grow thousands of acres of wild pot apparently is regarded as more practical than relying on their sense of obligation to society or on the laws of some states, including Illinois, which make it illegal.
>
> In the case of Turkey, that government for some time has had laws designed to control the marketing of opium and heroin, altho obviously they haven't been very well enforced. The United States now has resorted to paying Turkey what in effect is a bribe to enforce its own laws.

Only time will tell whether Turkey's opium farmers will comply with their government's new edict to stop opium planting starting with the 1973 season. Also, it is possible that many farmers will stockpile opium harvested in the 1971 and 1972 seasons to sell to the illicit trafficker now or later, at presumably increased prices, rather than sell it to Turkey's Government Monopoly Office, Toprak.

In forecasting whether this agreement with Turkey will successfully eliminate the planting of opium poppy plants after 1972, it is necessary to examine the history of the farmers' attitude relative to the control of opium production. In the past, many farmers declared to Toprak less acreage for poppy plants than they actually used. The harvest from the declared acreage was sold to Toprak, and the excess harvest was sold, at higher prices, to the illicit traffickers. There have been many recorded cases of armed battles when government army troops have attempted to seize this excessive opium harvest from Turk farmers. Consequently, it is reasonable to expect that regardless of "stringent controls" some farmers will try to grow opium clandestinely despite the ban which takes effect after the 1972 harvest. One need look no further than Mexico where opium production has been banned for many years but where clandestine production has prevailed nevertheless. In any event, given the most effective control system, the amount of clandestine production in Turkey should be far less than in the past.

Turkish opium and the intermediate substance, morphine base, have been traditionally funneled into the French black market for the final conversion into heroin, principally by Corsican-Frenchmen organized crime gangsters. A principal factor in France's growing interest in the suppression of this heroin conversion and wholesale international distribution, mostly to the United States, has been the continuing pressure applied by our government. Furthermore, France's own addict population has increased from 500 to an estimated 15,000 persons in just two years. The anti-narcotic unit of the federal enforcement authorities there has ten times the number of men it did a year ago. French narcotic agents have seized more than twice as much heroin and morphine base thus far in 1971 as they did for all of 1970.

An interesting contrast to the Turkish problem is the experience of India which is the

A drug addict injects narcotics directly into his vein. Equipment to prepare the injection is also pictured.

world's largest producer of opium. The Indians produce about 12,000 tons of opium a year, very little of which ends up on the illicit heroin market in this country. Several factors contribute to this. First, the geography of India, with its highly urbanized masses, is not conducive to conversion or smuggling. Second, the Indian Government, formed in the pattern of the British Civil Service, is far more efficient in controlling the legitimate output of opium. And third, India has its own addicts, so much of India's opium is consumed in India. Even more important than the controls is the Indian licensing procedure. The farmer is licensed to plant five acres of opium poppies. When the poppies have reached maturity, government officials inspect the crop and estimate the yield. If the farmer fails to deliver the estimated quantity to the government, he will not get a license the following year. In fact, failure to come up to the estimate may result in imprisonment.

Heroin Distribution

Heroin distribution, from the point of its manufacture to its ultimate receiver, the addict on the street, is strictly organized at all levels. Heroin traffic in the United States is controlled by 11 to 15 leaders of the organized crime syndicate. The exact number varies depending upon the authority consulted. These high echelon traffickers are known to the Depatrment of Justice, the Bureau of Customs, the Federal Bureau of Narcotics and Dangerous Drugs and various state and local law enforcement agencies. Three of these men are in prison. The fact that the remainder are free is indicative of the problems facing law enforcement authorities in prosecuting the large scale heroin importer.

The burden of detecting the heroin which smugglers bring into this country falls on the Bureau of Customs of the United States Department of the Treasury. That the dedicated men of the Bureau of Customs have been unable to halt the flow of narcotics into this country is due in part to the Bureau's chronic personnel shortage. Myles Ambrose, Commissioner of the Bureau of Customs, points out that it is almost ludicrous to note that in April, 1970, the total number of personnel in the Bureau finally exceeded the size of the staff when Calvin Coolidge was President of the United States.

The inventive genius of the heroin smuggler is amazing. His fertile mind is perpetually producing new ways of getting illicit heroin past customs officers. As law enforcement officials discover one ruse the smuggler invents another. Heroin has been smuggled into this country in false-bottomed gas tanks, in the sides of car doors, in the casing of electrical equipment, in hollow ski poles, in cans of Spanish food delicacies, and in towel dispensers of international airlines. Because of the relatively small size of a kilogram of pure heroin, the variety of places where it can be secreted is limited only by the imaginations of men growing rich on the misery of others. The compactness of heroin explains, in part, why enforcement activities have resulted in relatively small caches of heroin. The entire United States heroin supply for a year is estimated at between 8,000 and 10,000 pounds.* Theoretically this entire quantity could be carried across the United States border in two truck loads. The United States has 6,000 miles of land frontier with Canada and Mexico with 290 ports of entry. Most estimates indicate that something less than 10 per cent of the heroin brought into the United States is confiscated by law enforcement authorities.

* Some estimates far exceed this. The BNDD now estimates that as much as 13,000 pounds of heroin may be entering the United States annually. This figure is derived by multiplying the average daily heroin dosage times the number of addicts times the average percentage of purity. Thus, it is estimated that 300,000 addicts using 30 grains of 2-5% pure heroin per day would consume approximately 13,000 pounds, or 6½ tons, per year.

Tragically, most efforts fail to reach the higher levels of traffickers and frequently serve only to temporarily increase the street price of heroin.

Another factor which increases the problems encountered by customs men is the trend toward liberalization of international air travel formalities. Each year over 200 million persons enter this country on business or pleasure. The sheer crush of these passengers makes it virtually impossible to conduct adequate searches of persons and luggage coming into American ports of entry.

Heroin traffickers use equally sophisticated means to smuggle the morphine base from the the Middle East to Marseilles. In recent years, morphine has been discovered in goatskins, in bales of cotton, in hollowed out blocks of Turkish marble, and in loads of watermelons.

As the illicit heroin reaches the United States the organized crime syndicate which acts as the principle "importer" will pay about $8,000 a kilogram for pure heroin in multikilogram lots. A kilogram is the equivalent of 2.25 pounds. This pure heroin will change hands several times without being touched. A kilogram package costs between $8,000 and $12,000 at the second level of distribution and from $12,000 to $16,000 at the third level. It is at the third or fourth level of distribution (where the price can go as high as $25,000 a kilogram) that the heroin will be first diluted. Depending on which level of distribution and the level of his customers, the distributor will now cut his heroin anywhere between 20 and 50 per cent purity.

The heroin is now "cut" in earnest by wholesalers, distributors, and street pushers until it reaches the traditional "nickel bag." A "nickel bag" represents a quantity of heroin which retails at $5.00. A "dime bag" is a quantity of heroin which sells at $10.00.

In Chicago the nickel bag has become a rarity. In most instances the smallest quantity of heroin typically purchased is the dime bag. For his $10.00 the buyer usually receives a quantity of heroin less than 200 milligrams. Its level of purity usually ranges between 2 and 5 per cent.

Conclusion

Heroin has absolutely no redeeming medical or social value. The percentage of heroin users in the general population has increased steadily over the past ten years. Most of the other gauges of heroin abuse are similarly alarming. Heroin is spreading rapidly from the ghettos into all economic strata in America. Once unknown on the nation's campuses, today it is growing in popularity. Moreover, the age level of those who use the drug is decreasing. Today the 12 year old heroin addict is no longer a rarity. Most horrifying is the sickening increase in deaths caused by heroin overdoses.

Although law enforcement efforts against heroin have increased many times during the past two decades the volume of processed heroin finding its way into the United States continues to grow. Heroin arrests are escalating at an equally rapid rate. Unfortunately, most of these arrests are for low-level drug pushers and users. The organized crime hierarchy that imports the pure heroin remains virtually untouched. Nothing short of a major mobilization against heroin, beginning at the federal level, will win the war against this deadly drug. Although much remains to be done, an encouraging start has been made.


TURN
ON

Chapter 6
DANGEROUS DRUGS

Introduction

In this chapter our discussion will be limited to all dangerous drugs and substances exclusive of marihuana and narcotics. In this context the term "dangerous drugs" includes stimulants, depressants, hallucinogens, and other substances which are abused for their physiological effects.

Stimulants include any of several drugs which act on the central nervous system, producing excitation, alertness and wakefulness. Medical uses include the treatment of mild depressive states, overweight and narcolepsy—a disease characterized by an almost overwhelming desire to sleep. Stimulants of the amphetamine class have recently been used in the treatment of hyperkinesis—a disease which affects about three per cent of American elementary school children. The disease is characterized by poor attention in class, disordered behavior and intense physical and mental overactivity.

Depressants include any of several drugs which sedate by acting on the central nervous system. Medical uses include the treatment of anxiety, tension and high blood pressure.

Hallucinogens include any of several drugs, popularly called psychedelics, which produce sensations such as distortions of time, space, sound, color and other bizarre effects. While they are pharmacologically non-narcotic, they frequently produce effects which are far worse and more long lasting than any of the narcotic drugs.

The other "substances" mentioned above include an endless variety of non-drug items which are inhaled, eaten, swallowed and injected because of the peculiar sensations they cause. Common examples include catnip, airplane glue, oven cleaner, Murine, injectable peanut butter and morning glory seeds.

History

The abuse of dangerous drugs is a relatively recent phenomenon compared with that of

cannabis and the opiates. Obviously the abuse of these drugs had to await their development by medical science and their expansive production by pharmaceutical manufacturers.

1. *Cocaine.* Cocaine was first introduced in 1878 as a treatment for morphine addiction. It was obtained from the leaves of the coca plant *(Erythroxylon coca).* This is a small plant which grows abundantly on the slopes of the Andes. The shrub was sacred to the Incas and had been used by Aztec priests in religious rites. The effects of the plant were reported by Spanish explorers as early as the 16th century. Strangely, very little heed was paid to these reports. In fact, many scientists doubted the existence of the plant until the 19th century.

The South American Indians derived their exhilarating effects from the plant by picking the leaves, rolling them into little balls and then chewing them. A European traveler wrote in 1859 that coca was a harmless plant useful in treating fatigue, stimulating appetite, elevating the spirits and supporting sexual potency. Each of the effects mentioned is quite accurate. The following year, a Viennese scientist purified cocaine. The drug had been isolated in crude form five years earlier. It was first synthesized in 1885 by Merck. Cocaine was used in medicine as a local anesthetic and studied by Sigmund Freud who concluded that it was no more harmful than coffee or tea. The harmful effects were not discovered until years later.

Coca and cocaine were soon added to many patent medicines. One such concoction, developed by John S. Pemberton of Atlanta, Georgia, was known as "French Wine of Coca" in 1885. He then added extract from the kola nut to the formula and offered it as "a remedy for headache, a quick pickup." Finally he aromatized the preparation, adding syrup and introduced it for sale under the name Coca-Cola, "the intellectual beverage and temperance drink . . . valuable Brain Tonic, and a cure for all nervous affections." It should be pointed out that Coca-Cola still contains a "decocaineized" extract of coca leaves.

As late as 1896, coca and cocaine were widely advertised as safe products. But soon thereafter the hazardous effects of cocaine were discovered. For a time, cocaine was probably second only to opium as the most serious drug of abuse. In 1914, cocaine was classed with morphine under the Harrison Narcotic Act. In 1949 United Nation's action resulted in outlawing coca leaf chewing by the natives of Peru and Bolivia and the subsequent curtailment of the production of coca leaves.

2. *Depressants.* Alcohol is undoubtedly the oldest of the depressants known to mankind. However, it was not until the beginning of the 19th century that newer drugs were discovered to produce relaxation and sleep. Paracelsus had experimented with ether, which he called "sweet vitriol" in the 16th century, and Joseph Priestly had discovered nitrous oxide in 1772. But it was not until the beginning of the 19th century that these two anesthetics were given wide publicity by so-called "scientific demonstrations."

These formal lectures subsequently turned into traveling road shows. The shows featured demonstrations in public squares and circus tents of the curious effects of ether vapor and laughing gas (nitrous oxide). The demonstrations turned into laughing gas parties and ether frolics, and became of considerable concern to community leaders. Notwithstanding this hilarity, ether and nitrous oxide soon received serious recognition as useful anesthetics.

The sleep producing effects of chloral hydrate were discovered in 1868. This was the first of the synthetic sedatives introduced into medicine. It immediately gained wide popularity among physicians, as did paraldehyde, introduced in 1883 as "a safe hypnotic, producing sleep in fifteen minutes." But both substances soon gained notoriety in the criminal underworld where the hynoptics were used as "knockout drops." Many cases of death followed the use of chloral hydrate and paraldehyde with alcohol were reported during the last decade of the 19th century.

Barbiturates were introduced into medicine in 1903 by two German scientists. Their discovery, called Veronal, was offered as a controllable means of depressing the central nervous system to any desired degree from slight sedation to deep anesthesia. The barbiturates lend themselves to almost infinite chemical variation. In the past 50 years some 12,500 derivatives of barbituric acid have been synthesized.

As early as 1937, the American Medical Association took note of the "Evils from Promiscuous Use of Barbituric Acid and Derivative Drugs." According to the AMA report bearing the above title, these evils included habit formation, substitution of drugs for alcoholic beverages for drunken episodes and use of the drugs in suicides. Deaths from barbiturates rose alarmingly. During the 1940's, as production

of barbiturates tripled, so did deaths attributable to barbiturate overdoses. Approximately one half of these were accidental and about one half were suicidal. By 1949, approximately one quarter of all poisoning cases admitted to hospitals in the United States were due to acute intoxication from barbiturates. At the same time it was determined that sleeping pills caused more deaths, either by accidental ingestion or by suicidal intent, than any other chemical.

The Germans first recognized the fact that barbiturates can be addicting, including withdrawal symptoms consisting of convulsions and a psychosis resembling alcoholic delirium tremens. Dr. Harris Isbell at the United States Public Health Service Hospital in Lexington, Kentucky, subsequently concluded that "chronic intoxication with barbiturates is a true addiction."

The "pill poppers" soon developed their own special terminology. Barbiturates in general were known as "goof balls" and when they were dissolved in beer or other alcoholic drinks, the concoction was known as a "wild geronimo." Since alcohol and barbiturates are synergistic, the combination was found to produce a feeling not unlike heroin or morphine. One boy arrested in New York City for robbery while under the influence of a "wild geronimo" described the drink as "one that made you feel swell for a few hours after which it sends you into a sound sleep so that you could lie on a bed of hot coals and not feel it."

Each color-identifiable barbiturate was given a special name. Thus pentobarbital became known as "yellow jackets" and secobarbital was designated as "red devils" or "red birds." Amobarbital was known to the bootleg trade as "blue heavens." In the early days being under the influence of any barbiturate was known as being "goofed up." Today the term "stoned" is usually employed in reference to barbiturate intoxication as well as the effects of other drugs such as marihuana and heroin.

3. *Stimulants.* Amphetamine was synthesized in 1927 by a California pharmacologist, George A. Alles. After noting that amphetamines might serve as a suitable substitute for ephedrine and might also be absorbed into the body by inhalation, Alles turned his patent rights over to a pharmaceutical manufacturer. There, a scientist found that amphetamine had a pronounced vasoconstrictive effect. He also recommended that the drug be used in its vaporous state for relieving nasal congestion in hay fever, colds and other respiratory infections. Thus, the company introduced the Benzedrine inhaler in 1932.

The manufacturer's continuing research shows that obese patients taking the drug experienced an accompanying loss of appetite. Thus originated the idea of using the drug in weight reduction programs. In 1945, the company introduced dextroamphetamine, which was found to be equally useful in weight control. It also counteracted drowsiness caused by some drugs used in the treatment of epilepsy and was helpful in reducing anesthesia after surgery. Airmen in World War II relied on amphetamine for extra energy and alertness when flying long, dangerous missions. When the automatic controls failed on his space ship, United States Astronaut Gordon Cooper was ordered to take an amphetamine capsule so that his reflexes would be at their sharpest for his reentry into the Earth's gravitational pull on manual controls.

Unfortunately, newspaper publicity concerning the stimulating actions of amphetamines led to notoriety and abuses. Perhaps the first such abuse was found in 1936 at the University of Minnesota. Psychology students at the University who had been conducting experiments with different drugs tried amphetamines on themselves. They found that it would help them stay awake for "cramming." Thus was born a traditional vice of American college students.

The drug soon acquired a vogue for all sorts of conditions outside of the academic sphere. Truck drivers and night watchmen began using it to keep awake for their work. People from all walks of life began taking amphetamines as a "pick-me-up" or as a "pep pill."

A song entitled "Who Put the Benzedrine in Mrs. Murphy's Ovaltine" became a hit as a popular song. A newspaper advertisement offered a charm bracelet with a pill box attached stating: "For Benzedrine if you're having fun and going on forever; aspirin if it's all a headache." Bored "Broadwayites" began taking "bennies" along with barbiturates to get an effect that they called "a bolt and a jolt." Combinations of amphetamines with barbiturates in England became known as "purple hearts." By then, "dope" addicts had found "thrill pills" served as excellent "bombitas" to produce a better "high" than heroin alone.

Misuse brought about legal control in the United States, placing oral amphetamines into the prescription legend classification. Users were unable to get a supply of the original drug so they looked to the Benzedrine inhaler

(which was available without prescription) as a possible source. They bought up the Benzedrine inhalers, cracked open the tube, removed the Benzedrine-impregnated paper and soaked it in a hot liquid or soft drink. The contents of one inhaler held an equivalent of 25 amphetamine sulfate tablets. New phrases were coined as a result of this new Benzedrine inhaler such as "B-bombs" and "cracking a bennie."

This misuse continued despite a manufacturer's warning on the impregnated paper that it was for inhalation only, that it was unfit for internal use, and that there was "danger if swallowed." This warning did nothing to halt the numerous bennie parties which were being held across the country. The manufacturer then placed an emetic in the Benzedrine-impregnated paper. The "bennie-busters," however, found a way to separate it from the amphetamine. Left no other alternative, the firm finally removed the device from the market altogether in 1949.

Methamphetamine, a central nervous stimulant chemically related to amphetamine, was first widely used during World War II by the German army to counter fatigue among the troops. Because of its highly stimulating qualities, the German soldiers could engage in prolonged missions with very little sleep. Known by the abuser as "meth," "crystal," or "speed," it became a favored drug among habitual amphetamine users. The drug can be easily liquified for injection purposes. In this form it is probably the most hazardous drug on the street today. Apart from the highly corrosive effects of the drug itself, there is the added danger that the abuser will fail to completely liquify the drug. Injection of solid particles into the bloodstream produces an almost instantaneously fatal embolism. Despite this fact, and despite the hip warning coined in 1967 that "speed kills," methamphetamine continues to be a widely abused and dangerous substance.

4. *Peyote.* Soon after the Spaniards arrived in Mexico, they discovered that the Aztecs worshipped a variety of cactus and mushrooms. The most venerated species of cactus was called peyote. The Aztecs called it "the flesh of the gods."

The natives sought out the divine plant calling it the nourishment of the soul as well as food for the body. In keeping with its sanctity the holy plant is collected with the proper deference. Several weeks before the collection expedition departs (usually in October), the gatherers prepare themselves by chanting prayers, fasting, and abstaining from sexual intercourse. When they reach the plants, they shoot arrows into the air to the right and left of the plants to ward off the evil spirits. Then they dig up the cactus carefully and bring it back with great rejoicing to offer it on the altars. Some is kept for the great festivals and the rest is sold.

To preserve the drug, the cactus is cut into thick, fleshy slices which are laid in the sun to dry. These are commonly known as "mescal buttons."

This ritual spread steadily among the Indians, crossing the borders and invading the United States. It was adopted by the Apaches, the Omahas, the Kiowas and the Commanches. Christian missionaries were appalled at the Indians' delight in undergoing the hallucinogenic effects of the drug. The missionaries claimed that its use led the user to the pit of hell. The Indians retorted that it really brought them several steps nearer to heaven.

Typical of the Indian peyote rites are those of the Kiowas. The ceremony takes place on Saturday night. The men sit quietly forming themselves into a circle around a campfire. All bow their heads in prayer after taking mescal buttons. Each button is placed into the mouth and thoroughly softened, ejected into the palm of the hand, rolled into a bolus and then swallowed. In this way, as many as 12 buttons are consumed by each Indian between sundown and roughly 3:00 a.m. Throughout the ceremony the campfire is kept burning brightly and attendants maintain a continual beating of the drums. But there is no frenzied dancing. In fact, the Indians remain seated throughout the entire proceeding.

In an effort to halt the use of peyote, a case was brought into federal court in Wisconsin in 1914 against an Indian named Nah-qua-tah-tuck. He was charged with the crime of having received by parcel post on his reservation a package of peyote (which the government described as an "intoxicant"). The package had been sent from Laredo, Texas, where the cactus was growing within sight of the International Bridge connecting Mexico and the United States. The federal government brought a host of legal and pharmacological experts to Wisconsin for its test case. The defendant, a Menominee Indian, testified that, instead of being wicked, peyote was divine. He said that it was a religious rite of his to take peyote "so that his soul might go up to God." The clinching argument, however, came in testimony by Thomas Prescott, who told the court that he

had served as a "priest" of this new Native American Church of North America (the Peyote Society). At weekly services, the "priest" explained, the Indian parishioners either ate peyote or they drank it as tea and apparently with much benefit, for "they gave up drink, established themselves in regular homes and lived sober and industrious lives." The defendant was acquitted on the ground that he used peyote exclusively for performing religious rites.

These activities were not long tolerated. Soon a move had begun for national legislation. In 1918, Congressman Carl Hayden introduced a bill into the House of Representatives "to protect the Indians from evils such as peyote." He said that "it had immoral effects; it is demoralizing and excites baser passions." But the legislation never reached fruition. The United States Commissioner for Indian Affairs was petitioned to forbid peyote on Indian reservations, but Harold L. Ickes, Secretary of the Interior, under whose authority rested the Indian reservations, issued an order prohibiting "absolutely any interference by the Indian Bureau with the religious practices of the Native American Church." But by 1954, three states (Texas, New Mexico and Arizona—all on the Mexican border) had enacted legislation banning the transportation and sale of peyote. The Navajos became involved in a heated debate within their own ranks on whether or not this legislation was a curtailment of religious freedom when 13 leaders of the Native American Church were given sentences of from three to nine months in Navajo jails by a Navajo judge.

Peyote was added to the restricted drugs list in California and in 1962, Judge Carl Hilliard of the Superior Court in San Bernardino, found three Navajo members of the Native American Church guilty of violating the California state laws. In this case the American Civil Liberties Union became counsel to the defendants and appealed the verdict on the ground that the religious liberty of 250,000 Indians was threatened. The verdict was reversed by the Supreme Court of California in 1964 when it decided that the Indians did have a right to use peyote as a sacramental symbol since it was used by a Christian Church in place of bread and wine. "To remove use of peyote is to remove the theological heart of peyotism," the court declared, as the Indian carrying mescal buttons was compared with a Roman Catholic wearing a crucifix.*

* It is still a violation of California state law to possess peyote outside a church ceremony.

It was not until the end of the 19th century that Western scientists began to investigate the properties of peyote seriously. The earliest of these investigators to describe his personal experiences with the substance was the American physician, Weir Mitchell, who stimulated Havelock Ellis to experiment on himself. Ellis wrote:

> Every color and tone conceivable to me appeared at some time or another. Sometimes all the different varieties of one color, as of red, with scarlets, crimsons, pinks, would spring up together or in quick succession. But in spite of this immense profusion, there was always a certain parsimony and esthetic value in the colors presented.

Mitchell and Ellis had to take peyote in a crude decoction of the cactus root. But as scientists became increasingly interested in this curious Mexican cactus, they soon discovered nine alkaloids, the most potent of which they called mescaline. Among a host of experimenters who took the new alkaloid and reported personal observations was Aldous Huxley.

Peyote falls under Schedule 1 of the new federal Comprehensive Drug Abuse Prevention and Control Act of 1970. Peyote is also under Schedule 1 of the Illinois Controlled Substances Act, and is also controlled by 23 other states.

5. *LSD.* In the late 1930's, Albert Hoffman and his colleagues at the Swiss laboratories of Sandoz had been working on chemical modifications of ergot alkaloids when they produced a compound known as lysergic acid diethylamide tartrate (LSD-25). One day in 1943 as Hoffman was studying the compound, he accidentally ingested or inhaled some LSD and wrote in his laboratory report:

> I had to go home because I experienced a very peculiar restlessness which was associated with a slight attack of dizziness. At home I went to bed and got into a not unpleasant state of drunkenness which was characterized by an extremely stimulating fantasy. When I closed my eyes I experienced fantastic images.

Hoffman had prepared and was the first to test the most potent hallucinogen thus far discovered. Studies were undertaken to determine how LSD works. By 1960, illegal production, distribution and use of LSD began to increase. Researchers at Harvard began giving the drug to students outside a proper research setting. Soon this practice spread throughout

the country spurred by publicity and by those who came to view LSD as a symbol of protest against traditional society. The LSD movement was further motivated by Timothy Leary and Richard Alpert, the former Harvard psychologists who founded the International Federation for Internal Freedom. IFIF encourages the use of hallucinogens which Leary calls the "road to happiness."

6. *Other drugs.* While the LSD cult was forming, other experimenters, such as Gordon Wasson, were studying the mushroom cult of the Indian tribes of southern Mexico. By 1956, chemists had succeeded in isolating and identifying two separate chemicals—psilocybin and psilocin—from the fungus growing on various species of mushroom.

The list of substances of abuse seems to go on endlessly. The drug culture discovers a new psychotoxic substance virtually every week: morning glory seeds, catnip, banana peel, Murine—the list is almost infinite. But lest we think of this proliferation as a recent phenomenon, a look at history will prove informative. We must recall that arsenic was used in Austrian villages three-quarters of a century ago to produce stimulating effects. Strycnine (still used today to "spike" LSD) has been employed for over a century as a stimulant. Jamaica ginger was a popular "jag" producer 70 years ago, as was the extract of lavender, which was served in New York social circles. At the same time capsicum extract became popular in England.

Government Response

Abuse of the stimulant and depressant drugs did not become a major law enforcement problem until the mid-1950's. At that time, through over-prescriptions by doctors and diversions from legitimate drug shipments, thousands of newly-created drug dependent persons began to appear throughout the country. By the early 1960's the first of the hallucinogens, LSD-25, began to appear on our nation's college campuses.

The growing abuse of these drugs was noted by the 1962 White House Conference. Discussions concerning this trend were held in the World Health Organization of the United Nations even before then. In 1966, the Medical Society of New York reported that, while drug abuse in the state's high schools and colleges was not yet a major problem, it threatened to become one very soon based on discernable trends. This prediction was to be realized by the end of the decade.

By the mid-1960's the federal government began to mobilize its efforts against the new illicit traffic in non-narcotic drugs. In 1965, proceeding from a recommendation by the President's Advisory Commission on Narcotic and Drug Abuse, the Drug Abuse Control Amendments were added to the Food, Drug and Cosmetic Act of 1938. The Amendments provided for stronger regulation of the manufacture, distribution, delivery, and possession of stimulants, depressants and hallucinogens. They also provided strong criminal penalties against persons who dealt in these drugs illegally. The Food and Drug Administration of the Department of Health, Education and Welfare was given stronger enforcement powers to prevent drug counterfeiting. The purpose of these Amendments was to eliminate illegal traffic in amphetamine, barbiturates, and hallucinogens. To enforce these Amendments a Bureau of Drug Abuse Control was created under the Food and Drug Administration to regulate distribution of amphetamines, barbiturates and other abused non-narcotic drugs.

In 1968 this Bureau was merged with the Federal Bureau of Narcotics of the Treasury Department to create the new Bureau of Narcotics and Dangerous Drugs. The new agency was placed under the Department of Justice and given enforcement powers over all drugs of abuse including both narcotic and non-narcotic substances.

All of these drugs are now included in the new Comprehensive Drug Abuse Prevention and Control Act of 1970. This legislation, like the recently enacted Illinois Controlled Substances Act, classifies narcotics and dangerous drugs according to several criteria which reflect the relative dangers of each drug with corresponding penalty provisions.

The same schedulized approach is reflected in the proposed treaty generated by the Convention on Psychotropic Substances on February 21, 1971. The Convention addressed itself to establishing an international agreement regarding stimulants, depressants and hallucinogens. The drugs included in these classes are all those which were not classed as "narcotics" in the Single Convention of 1961. As defined in the Single Convention, "narcotics" included cocaine and marihuana in addition to the true narcotic drugs.

The Psychotropic Convention was held in Vienna and was attended by 94 nations. To

date, 20 have signed the draft treaty subject to ratification by their governments. On June 29, 1971, President Nixon sent a copy of the treaty to the Senate as the first step in securing United States ratification.

The treaty is modeled after the 1970 Federal Drug Act. Four schedules are provided for the drugs according to their degree of medical usefulness, potential for abuse and other relative standards. The first schedule contains most of the hallucinogens, such as LSD, since they have little or no medical usefulness. The second schedule contains most of the stimulants such as the amphetamines, methamphetamine, phenmetrazine, PCP and other related drugs. The third schedule contains the short-acting barbiturates and similar depressants. The fourth schedule includes the long-acting barbiturates, tranquilizers, and all other psychotropic drugs not included in the previous three schedules.

Basically, the signatory countries agree to abide by the terms of the treaty as they pertain to international controls on drug traffic. For example, they agree to exchange import and export certificates, and to limit manufacturing. Secondly, they promise to enact legislation in their own countries designed to reflect the principles set forth in the treaty.

These expressions of governmental concern reveal the growing menace of dangerous drugs abuse. Recent statistics show that barbiturates may be just as deadly as heroin. Most authorities now agree that liquid methamphetamine is the most explosive abused drug in existence. And the thousands of tragedies generated by the hallucinogens is further proof of the nightmare produced by the multi-faceted onslaught of the dangerous drugs.

Cocaine

Cocaine is a stimulant drug which grows mainly on the western side of South America. The leaves are treated with lime to release the cocaine. Once used widely as a local anesthetic in oral and nasal surgery, it has been replaced by newer less dangerous drugs.

Cocaine is a white or colorless crystalline powder which is abused by inhalation and injection. It can induce euphoria, excitation, anxiety, a sense of increased muscular strength, talkativeness, and a reduction in the feeling of fatigue. The pupils become dilated, the heart rate and blood pressure increase, and the skin temperature decreases. The resultant stimulant properties of the drug affect both local nervous system and higher levels of brain activity. In larger doses, cocaine can produce hallucinations and paranoid delusions. Stimulation is followed by depression. In cases of overdose, breathing and heart functions may be so depressed that death results.

Because of the intense stimulation received from this drug, most abusers voluntarily seek sedation, sometimes combining depressant drugs with cocaine. A commonly observed combination is that of cocaine and heroin. This concoction is called a "speed ball."

No physical dependence develops with cocaine, nor is there a characteristic abstinence syndrome or tolerance. The cocaine abuser does, however, feel a strong psychological dependence. When use is stopped, he may feel depressed and hallucinations may persist. Since cocaine is metabolized incredibly quickly, its effects wear off almost as fast as they came on. This leaves the user, if not in need of the drug, hungry for more. The depression that follows the cocaine high is fully as dark as the ecstacy was brillant.

Coca leaves, large cocaine crystals and pulverized cocaine.

In many circles cocaine has become the "in" drug. One explanation for the growing popularity of cocaine is mentioned in William S. Burroughs' controversial novel, *Naked Lunch:*

> The pleasure of morphine is in the viscera. You listen down into yourself after a shot.

But C [cocaine] is electricity through the brain, and the C yen is of the brain alone, a head without body and without feeling. The C-charged brain is a berserk pinball machine, flashing blue and pink lights in electric orgasm.

The praises of cocaine have been sung in other recent books as well. Claude Brown's probing analysis of the black ghetto, *Manchild and the Promised Land,* contains a detailed description of the author's experiences with cocaine. He gives particular emphasis to the feeling of well-being and sexual prowess produced by the drug. Other writers have compared the effects of cocaine with the state that Greek classics called *ataraxia* — the most blissful of all states, in which mental serenity is combined with physical well-being.

Cocaine has become especially popular with musicians. This is particularly true of many rock and roll stars. In their drug oriented existence, cocaine has become analogous to morphine in the same way that champagne is to beer. In their best-selling album, *Sticky Fingers,* the Rolling Stones refer to cocaine. In the song, "Sister Morphine," Mick Jagger, the lead singer of the group, mentions "Sister Cocaine" in the middle of the song and takes a long, pronounced sniff. This obviously mimicks the traditional way in which cocaine is administered, i.e. by sniffing it through the nose.

Indeed, along with the marihuana paraphernalia sold in head shops, tiny spoons are now being sold. These spoons are to cocaine what roach clips are to marihuana: tools of the trade. A small spoon holds just enough of the white powder to insert in one nostril and "snort" with a sharp intake of air. Some of the spoons have been imbedded in .30-caliber cartridges just as was the case with the "bullet for peace" cartridges used to house a removable roach clip. The spoons come in ivory, wood and a variety of metals. Many are suspended on chains. More opulent users have purchased sterling silver and gold plated baby spoons for use in sniffing the drug.

The term "spoon" also figures in the buying and selling of the drug. In Miami and New York, a spoon constitutes one half of one gram. This is enough for two to five people to "get off" on. This same quantity describes a spoon in Chicago. In California, however, a spoon is a full gram.

High-purity cocaine is the most expensive drug on the illicit market. It is said to play an important role in the West Coast occult groups and among the Hollywood movie set. *True* magazine recently claimed that perhaps the most powerful man in Los Angeles is the city's biggest cocaine dealer with "clients" from people in city government to the highest levels of the "hip" establishment. There are, however, a large number of pushers and small-time hustlers who deal in cocaine. Pimps and prostitutes also frequently deal in cocaine because of its local anesthetic powers in prolonging the sex act and inducing a sense of euphoria. It is not uncommon for guns and violence to play a role in power moves for larger shares of the cocaine market.

Most of the cocaine on the streets today is far from pure. Very frequently, what is sold as "cocaine" is in fact a mixture of procaine, a dental anesthetic, and methedrine. The best cocaine comes from South America. A synthetic form of cocaine comes from Germany. It is receiving wide-spread acceptance by the drug underworld. It is called Merck Extra Pure Salt, and on the black market it sells from $800 to $1,000 an ounce if the factory seal is uncut. On the legitimate market the salt is used as a local anesthetic. Physicians and pharmacists can purchase the substance for $18.40 an ounce.

Most natural cocaine is shipped from Peru or Bolivia. In those countries $5 is paid to Indians in the Andes Mountains for enough cocaine leaves to make one pound of crude cocaine.

This crude cocaine, or cocaine "paste," is then processed into cocaine crystals, the final product. From South America the cocaine is principally smuggled to the United States, via Caribbean countries. The main port of entry into the United States is Miami, Florida where the wholesale "connection" pays the smuggler from $10,000 to $14,000 a kilogram (2.2 pounds). Almost all of the cocaine is smuggled into this country either by seamen couriers or airline passengers, concealed on their bodies. Occasionally, cocaine is concealed inside legitimately shipped merchandise.

The wholesale connections in Miami, usually of Cuban origin, then sell to major gangster distributors in New York City, Chicago and other large metropolitan areas at a profit of about $5,000 a kilogram. In most instances these distributors operate "factories" where the cocaine is further adulterated or "stepped on." By the time the original $500, one-pound quantity of pure cocaine crystals reaches the street traffic, in a greatly adulterated form, it is valued in excess of $100,000. This figure is computed

on the basis of the series of adulterations and levels of profit made from the time the cocaine is first smuggled to our shores.

A surprisingly large percentage of the cocaine will find its way to college campuses and to gathering spas for urban dwelling young adults. Most cocaine users are convinced that cocaine is absolutely harmless. For this reason it is relatively simple to find "pushers" for the drug. Most sellers who peddle cocaine, marihuana, and other non-addictive drugs rationalize their efforts by pointing out the fact that their wares, unlike heroin, do not produce an addiction and do not produce fatal overdoses. Both buyers and sellers, however, have exhibited a remarkably naive perception of the dangers associated with the use of cocaine.

Dr. Fred Hofmann, Professor of Pharmacology at the Columbia University School of Medicine, reports that heavy users of cocaine develop some degree of tolerance. This explains why there have been remarkably few deaths from overdoses. The fatal overdose, however, is always a real possibility. Moreover, strong doses over short intervals produce a toxic psychosis similar to paranoid schizophrenia. The old notion of the drug addict as a violent criminal was derived from people who had taken enough cocaine to precipitate a paranoid psychosis in which they violently assault anyone who happens to come by.

Amphetamines

Amphetamines are prescribed for overweight patients to reduce their appetites; in cases of narcolepsy, a disorder characterized by an overwhelming need for sleep; for Parkinson's disease; to correct inattentiveness and overexertion particularly among children (hyperkinesis); and in some cases of minor mental depression because of their mood-elevating effect.

Amphetamine-induced effects may be conveniently divided into those producing stimulation of the central nervous system (brain and spinal cord) and those that have a peripheral site of action. The majority of clinically available amphetamine-like drugs act more selectively on the central nervous system; hence, with therapeutic doses, the user is alert, has a decreased sense of fatigue, elevated mood, and has enhanced initiative, confidence and the ability to concentrate; he is elated and experiences euphoria; increased motor activity and talkativeness is observed; appetite is suppressed. Because the body develops a tolerance to amphetamines, abusers increase their dosages gradually, which wildly exaggerates the normal effects of these drugs, and results in excitability, uncontrollable talkativeness, tremor of the hands, enlarged pupils, heavy perspiration, increased heart rate, elevation of blood pressure, flushed warm skin and dryness of the mouth. Often this last effect produces soreness of the tongue with possible ulceration. In cases of prolonged intensive usage hyperacousia and illusions may develop. In serious cases, a drug psychosis resembling schizophrenia develops with delusions and hallucinations both auditory and visual. Moreover, with very large doses, there are alterations in the normal rhythm of the heart (cardiac arrhythmias), involuntary oscillations of the eyes (nystagmus), dizziness, slurred speech, headache, nausea, profound insomnia and disorientation. These effects are particularly dangerous to long-distance drivers. They may take amphetamines to avoid the need for sleep, and may be unaware of their fatigue until it overcomes them, resulting in serious highway accidents. In addition, it has been suggested by some criminologists that criminals may use amphetamines to increase their courage and altertness during their exploits.

The hazards associated with heavy or prolonged use of amphetamines recently caused the American Medical Association to assume a firm stance against indiscriminate use of these drugs and other stimulants by physicians. On July 25, 1971, the AMA's policy-making House of Delegates called for tighter government control over amphetamines and called on drug manufacturers to curve their production of these drugs.

A motion to ban amphetamine use in obesity treatment was presented by Dr. Alan P. MacFarlane of Salt Lake City, who stated that the Utah State Medical Society had fought to ban the use of these pills for obesity and that the society had already observed a significant reduction in the abuse of these drugs. The action taken by the delegates urged "all physicians to limit their use of amphetamines and other stimulant drugs to specific, well recognized medical indications." This recommendation was instrumental in the Justice Department's decision to reclassify amphetamines as a Schedule II drug, in the new Federal Controlled Substances Act. It has been shown that continued abuse of amphetamines frequently produces severe emotional disturbances, such as toxic psychosis or paranoid reactions. Amphetamine psychosis is the most dramatic consequence of amphetamine abuse.

While the findings of investigators vary, Kalant summarized the relative incidents of symptoms of amphetamine psychosis in 94 reported cases: delusions of persecution (83%), visual hallucinations (54%), auditory hallucinations (40%), tactile and olfactory hallucinations (18%), and excitation (41%). Unlike many other drug psychoses, the amphetamine abuser is generally able to think clearly and able to have an excellent recollection of relevant and extraneous facts during the period of psychosis.

Most persons (80%) taking heavy doses of amphetamines become suspicious. In the early stages, users are suspicious of their family, friends, lovers and especially strangers. At intermediate stages, they think they are being followed by federal agents or by the police. In very advanced cases of abuse, patients not only think that they are being monitored but also that they are being manipulated, *i.e.*, by radio or television transmitters or by unknown power sources in which they in turn manipulate others.

Similarly, in early stages visual hallucinations begin as fleeting glimpses and progress to fully formed recognizable figures. Auditory hallucinations start as simple noises; whereas in the more psychotic stages, the patient carries on long conversations with his persecutors.

The drug user is aware of his paranoid reactions and learns to live with them. There are no physical signs by which to diagnose amphetamine intoxication. The mental picture may be indistinguishable from that of acute or paranoid schizophrenia, or of alcoholic hallucinations present during the withdrawal phase of alcoholism. These psychotic symptoms generally subside spontaneously about one week after the drug is discontinued.

Most persons who develop an amphetamine psychosis have been shown to have a high incidence of pre-existing abnormal and unstable personalities. In many cases they are disposed to alcoholism and other drug dependent states. However, these reactions have also been known to occur in normal, well-adjusted individuals. At present, there is no specific treatment during the psychotic phase; rather, therapy is directed toward curing the dependency state.

Amphetamines are known to drug abusers as "pep pills," "wake-ups," "eye-openers," "co-pilots," "truck drivers," "bennies," or "dexies." As with other dangerous drugs the slang names frequently are derived from the shape and colors of capsules and tablets and their effects or actions. Amphetamine sulfate is produced in rose-colored, heart shaped tablets which are known as "peaches," "roses," "hearts," or "bennies." The same drug in round, white, double-scored tablets is called "cartwheels," "whites," or "bennies." Long-acting amphetamine sulfate capsules found in many colors are known as "coast-to-coast," "L.A. turnabouts," "co-pilots," or "browns." Amphetamine sulfate in oval shaped tablets of various colors is called "footballs" or "greenies." Injectable amphetamine sulfate in the jargon of the abuser is called "bombido," "jugs," or "bottles." Dextroamphetamine sulfate in orange-colored heart-shaped tablets is known as "hearts," "oranges," or "dexies" (after a trade name).

Recently, several amphetamine-like derivatives of mescaline have been synthesized which are more active than mescaline. The one most widely used by the "hippie" population is 4-methyl, 2, 5-dimethoxy-amphetamine (DOM), more widely known as STP. It is estimated to be 50 to 100 times as potent as mescaline in hallucinogenic activity. Unlike amphetamine, STP is not used in medical therapeutics; it is exclusively a drug of abuse.

The capacity of the amphetamines to elevate mood and induce a state of well-being is the basis for their value and wide-spread use as stimulants and anuretics. This therapy commonly involves continuous and prolonged administration. As a consequence, varying degrees of psychic dependence may develop. Susceptible persons may increase the quantity or frequency of administration in the hope of obtaining a continuing state of elation. The psychotoxic effects of extremely large quantities may lead to aggressive and dangerous antisocial behavior.

Abuse of amphetamines and related substances arises from and is perpetuated solely by the psychic drives to attain maximum euphoria. Qualitatively these psychological effects are similar to those produced by cocaine. However, cocaine is a much more dangerous agent, and a qualitative comparison would not be valid. In contrast to the amphetamines, cocaine is capable of inducing severe cytotoxic effects in nearly all tissues, including the brain.

A unique feature of the amphetamines is their capacity to produce tolerance. This property is possessed by only a few central nervous system stimulants. Although tolerance develops slowly, progressive increments in dosage permit ingestion of amounts hundreds of times greater than the original therapeutic dose. A

daily ingestion of 1700 milligrams of amphetamines has been reported. Progressive increases in dosage over many weeks in clinical experiments has permitted monkeys to tolerate 10 to 20 times the average lethal convulsant dose. It would appear that all the components of the cerebral system do not become tolerant at the same rate. Thus a user will experience increased nervousness and insomnia as the dose is increased. Ingestion of very large quantities may produce profound behavioral changes often of a psychotoxic nature including hallucinations and delusions. The later effects are much more likely to occur following intravenous injection. Indeed, addicts take amphetamines by injection for the purpose of obtaining bizarre mental effects often associated with sexual fantacies, even orgasm. After initial phases of experimentation, a special pattern of intravenous amphetamine use emerges. The drug is injected every four to six hours while the individual remains awake. The intravenous amphetamine user gets a sudden euphoric "flash" or "rush" characterized as a full body orgasm. The "run" usually lasts for several days. The individual falls into an exhausted sleep, awakes depressed and starts "shooting" again. A dosage may get extremely high. Repeated use of the amphetamines and progressively higher dosages causes and often terminates in an acute panic reaction or extreme toxic psychoses with hallucinations.

This type of abuse has increased since World War II both in this country and elsewhere. In Japan a serious criminogenic problem was created when many thousands of juveniles took dextroamphetamine intravenously for "kicks." It was estimated that as many as 500,000 juveniles were involved. In 1954 a total of 55,664 such juveniles were arrested. Although this abuse of amphetamines has been largely suppressed, it has been followed by abuse of other similar agents. Currently, ephedrine seems to be the primary stimulant drug of abuse in Japan. Similar wide-spread amphetamine abuse problems are currently being experienced in Sweden and England.

Although amphetamines do not induce physical dependence as measured by the criterion of a characteristic and reproducible abstinence syndrome, it would be inaccurate to say that withdrawal from large dosage levels is without symptoms. The sudden removal of a stimulant drug which has masked chronic fatigue and the need for sleep permits these to appear in an exaggerated fashion. The withdrawal period is characteristically a time of depression, both psychic and physical. This depression probably reinforces the drive to continue the drug. However, the withdrawal of amphetamines is not comparable to the withdrawal of morphine, barbiturates, alcohol, and other substances which create physical dependence. It is never life threatening and requires psychological rather than supportive therapy.

Abuse of amphetamines by self-administration has increased steadily since World War II. In addition to traditional abuse by persons such as students and truck drivers, amphetamines have also been used to enhance the physical performance of athletes and race horses. Abuse has been fostered in some large urban centers by irresponsible physicians who operate "anti-obesity" clinics whose main function is to dispense amphetamines legally on a mass basis often without examination or follow-up observations. These doctors have been referred to in recent years as "fat doctors." Some significant steps have been taken against these physicians through warnings of local medical societies or by license revocations.

There has also been an appreciable increase in the use of these drugs as stimulants by persons who abuse alcohol and barbiturates. Many times they become part of the picture of mixed dependence. The prognosis is poor, the relapse rate is high, and continued dependence on these or other drugs is the rule, especially among pre-psychotic persons or those with latent schizophrenia.

A large number of amphetamine users are members of the vast middle class. Most individuals who are heavily involved with amphetamines pass unnoticed as our friends and neighbors. Public attention, however, is generally directed toward the thrill-seeker who has attempted to change his perception of society by the elevation of his mood and outlook. In a 1966 article appearing in the *Journal of the American Medical Association,* it was suggested that 35 tablets of amphetamine-like drugs were legally produced for every man, woman, and child in the United States. Moreover, it was estimated that one half of this production entered illegal markets. Abuse by the vast middle class has been emphasized because it enables one to understand who is at least partially responsible for the enormous consumption of stimulants.

Recently a study was conducted of the backgrounds of 60 patients, all high abusers of amphetamines, who were admitted over a 22 month period to Bellevue Psychiatric Hospital. The

patients ranged from 17 to 41 years of age with an average age of 25; of these, 71 per cent were males and 30 per cent were females; 52 were white, 7 were Negro, and there was a Puerto Rican. The duration of amphetamine usage ranged from 20 years down to one time only, with a mean of 3.7 years.

Connell has classified amphetamine users as being of seven types, based on the nature and extent of their drug abuse:

Type 1: Takes the drug only once, as an experiment, in the company of friends and never takes it again;

Type 2 and 3: Take amphetamines only on weekends, and markedly reduce their intake as the weekend draws to a close;

Type 4: Mainly is characterized by weekend use of the drug, with major amounts during the weekend to combat the rebound depression;

Type 5: Uses amphetamines for only a short period and rapidly progresses to more potent drugs such as cocaine and heroin;

Type 6: Requires amphetamines to carry on normal activities on a daily basis. This type of individual is generally a middle-aged user whose physician initially prescribed amphetamines for the treatment of obesity or mild depression. Consumption is generally two or three to seven or eight tablets per day. Many upper middle class matrons fall in this category;

Type 7: Uses amphetamines for months or years and progresses to more potent drugs.

Not long ago (1969) a survey was conducted of 1300 students in five San Francisco Area colleges. The study indicates that amphetamine abuse is apparently a relatively minor problem when compared with the use of other drugs. Only 21 per cent of the students indicated that they had ever used amphetamines.* Of this number only 8 per cent reported having any difficulty in obtaining their supply of drugs. In this survey, the characteristics of the "typical" college amphetamine abuser included: an individual who was an older, upper-classman who began abusing drugs at 18 or 19 years of age; he was an arts, humanities, or biology major; he came from a wealthier family with one or both parents dead or he was from an unsettled family; except for political interests (generally radical left), the youth had few outside interests such as sports or religion. Possibly, with the growing acceptance of amphetamines among college youth, a study performed today would indicate that current abusers do not have nearly the same etiology.

Often the students saw little relationship between studies at school and their life or career aspirations. Understandably, use of amphetamines appeared to be more prevalent among students who had recently taken "incompletes" in one or more courses, who had dropped out of school earlier or who had contemplated dropping out. Notwithstanding this, the grade point average of users was 2.8 where as non-users had a 2.7 average. This is perhaps attributable to the increased energy and alertness produced by *moderate* amphetamine use.

There appeared to be a variety of reasons for using amphetamines such as: to gain courage, to better understand oneself, to seek religious or spiritual experiences, to relieve boredom, to combat depression, to calm nervousness, to facilitate friendliness, and to improve physical and mental performance.

It is interesting to note the apparent parental influence on patterns of amphetamine use. Whereas this study showed that 31 per cent of the parents of intensive users had used amphetamines, only 19 per cent of the parents of light users and 5 per cent of the parents of non-users took amphetamines.

Most amphetamine abusers in the colleges included in this study were observed to use other drugs such as alcohol (99%), tobacco (87%), marihuana (44%), such sedatives and hypnotics as barbiturates (33%), tranquilizers (32%), hallucinogens (17%), and opiates such as heroin (4%).

Numerous studies have shown that the majority of young amphetamine abusers are introduced to the drug in their own homes. Many simply initiate their dependency by taking amphetamines which they find in the parents' medicine cabinets. After the introduction is made, frequently the youthful abuser will turn to his neighborhood or campus pusher for an increased supply. Today, many youthful pushers sell a wide variety of drugs including pills, marihuana, and even heroin.

* Very likely this percentage has increased significantly since 1969. In the course of the Commission's tour of California facilities, we were repeatedly told that the use of amphetamines was escalating rapidly. This was particularly true in the San Francisco Area.

The pusher frequently obtains his supply of amphetamines by robbing or pilfering from legitimate pharmaceutical supply warehouses. Thefts from manufacturers have grown increasingly common as the demand for amphetamines grows. Such a theft occurred in a processing building at Abbott Laboratories in North Chicago in April, 1971. A check of the building revealed that a container drum was missing, filled with 180,000 capsules of methamphetamine hydrochloride and phenobarbital. An earlier inventory disclosed that another drum, containing 13 pounds of amphetamine powder and 5,000 pills was also missing. The powder was enough to make 600,000 pills, according to company officials. Howard Stried, Assistant North Chicago Police Chief, theorized that the burglars were familiar with the layout of the processing building because they took the amphetamines and left less valuable drugs behind.

Other methods of acquisition includes purchasing them from illicit manufacturers or from smaller manufacturers on the pretense of being engaged in scientific research. Less frequently, the pusher gets them from a small group of scientists or physicians who sell these drugs illegally.

The user may obtain his drugs on a legitimate prescription, or by stealing prescription blanks and forging them. They may also be procured from a small group of pharmacists who supply them without prescription or from the omnipresent pusher. "Splash" (amphetamine) parties, originating from the user's desire to be among friends, represent another channel of distribution. Eventually more enterprising individuals organize these parties, with profit as the incentive.

Recognizing the increased incidence of amphetamine abuse in this country, the Federal Government has recently brought amphetamines and amphetamine-like compounds under strict legal controls. Under the new Federal Drug Law, all manufacturers, physicians, hospitals and pharmacies are required to maintain a perpetual inventory which must be submitted periodically to the Bureau of Narcotics and Dangerous Drugs. Without advance notice, they are subject to inspection by federal agents. Under new federal regulations which became effective August 6, 1971, doctors must write a new prescription whenever a patient needs a new quantity of amphetamines or related drugs. Prior regulations permitted five refills of a prescription for amphetamines or methamphetamine during a six month period. The stricter regulations were part of an order reclassifying the drug to a higher schedule under the federal law because of what Attorney General John M. Mitchell called their "potential for abuse." Similar controls are contained in the new Illinois Controlled Substances Act.

The Commission has concluded that controlling the amphetamine abuse problem should be a major goal of both Federal and State Government. Vigorous inspection of all legal channels of drug distribution including manufacturers, wholesalers, hospitals, physicians and pharmacists should be conducted on a perpetual basis. Attempts to eliminate illicit manufacture of these drugs in Illinois and elsewhere should be stepped up. Federal authorities should continue their efforts to prevent illegal smuggling of the drugs from abroad. Judges should impose strong penalties upon illicit large scale pushers who supply drugs to the users. The various medical schools, associations, and health organizations should improve the education of physicians and the drug using public about the dangers inherent in the misuse of these drugs. State schools should make every effort to supply purely objective information about these drugs to students from the elementary school to university levels without sermonizing since the facts speak for themselves. Since chronic amphetamine abuse is a medical problem, psychiatric and clinical help should be offered to those who are dependent on the drugs without police involvement.

Although at present amphetamine abuse has not reached epidemic proportions among youths of high school and college age in the United States, its incidence appears to be increasing. The Commission views this increase in amphetamine abuse with particular alarm. Every effort should be expanded to insure that such use for non-medical purposes is seen as a very real danger to the physical and mental health of the people of Illinois.

Methamphetamine

Methamphetamine is chemically related to amphetamine, but it has more central nervous system activity and correspondingly less effects on blood pressure and heart rate. When used under the careful supervision of a physician, methamphetamine has several benefits.

The abuse of methamphetamine, which is often called "speed," "crystals," or "meth," is more wide-spread than ever before. Many abusers "shoot" (take intravenously) methamphetamine and eventually many build up to doses more than 100 times the safe medical

dosage and many do so several times a day. Thus, it is not surprising to observe these persons in an acute toxic state which may result in very serious outcomes. Many drug authorities have come to regard injectable methamphetamine as the most hazardous of all drugs. These views and other incontrovertible evidence led the Commission to classify methamphetamine as a Schedule II drug under the new Illinois Controlled Substances Act. But for the fact that there is a recognized medical use for methamphetamine it would have been classified as a Schedule I drug.

The acute toxic effects of methamphetamine are propelled by increased activity without the necessary judgment and consideration that should accompany this increase in activity. Irritability, confusion, assaultiveness, delirium, and hallucinations, all followed by depression and fatigue, are common effects. Indeed the drug culture slogan "speed kills" is not just a play on words. Methamphetamine's lethal qualities are respected even in the hippie world. Additional dangers to those who "mainline" or "shoot" methamphetamine are the possibilities of infection and hepatitis from the use of non-sterile injection equipment, and the risk of blood clotting due to undissolved particles.

Chronic or long-term use can lead to intoxication characterized by similar symptoms as described for acute overdosage. In addition, toxic psychosis and other abnormal mental states may occur. It has been shown experimentally that physical traces of this stimulant are observed in organs of chronically treated animals.

Although physical dependence does not develop to methamphetamine, mild to severe psychological dependence can occur. In addition, tolerance is produced, especially in its effects on the central nervous system. Thus, abusers increase their daily dosage to several hundred times the medicinal dosage in order to achieve the desired effects to the central nervous system.

Obviously, methamphetamine is available for medical purposes on prescription only. It is produced commercially under a variety of trade names. However, it is also manufactured in clandestine laboratories and is available in illicit channels as crystalline powder, tablets, and a variety of liquid forms.

Barbiturates

Barbiturates depress the central nervous system. They are prescribed in small doses to induce sleep and they are valuable in cases of anxiety, hyperthyrodism, and high blood pressure. They are also used as a sedative (*i.e.*, for a more depressant effect than tranquilization with the possibility of drowsiness) or as a hypnotic. Due to their sedative but non-analgesic effects, barbiturates are used to treat both physical and mental illnesses. Certain barbiturates (*e.g.*, phenobarbital) are used in various types of convulsive disorders caused by such conditions as epilepsy and tetanus, or drugs such as strychnine. Barbiturates are also widely used in hospitals to sedate patients prior to surgery. Besides easing anxiety and tension barbiturates also relax the patient so that the necessary pre-operative procedures may be carried out quickly and efficiently. Finally, the ultra short acting barbiturates (such as thiopental) are widely used as anesthetics for brief surgical procedures. Dentists also use thiopental anesthesia for tooth extraction or for filling several cavities at one sitting.

Continued and excessive dosages of barbiturates result in slurring of speech, staggering, loss of balance and a quarrelsome disposition. Overdoses, particularly when taken in conjunction with alcohol result in unconsciousness and death, unless proper medical treatment is given to the user.

Overdosage of barbiturates may occur accidentally or intentionally. Accidental overdosage may result from the individual becoming confused about the amount of time that has passed between doses of barbiturates. For example, an individual might take a barbiturate capsule before retiring to help him get to sleep. The person goes to bed and perhaps dozes off for 30 minutes, wakes up and decides another capsule is necessary. This may continue until several capsules have been ingested. The more barbiturates consumed the more disorganized and confused the person becomes. This may eventually lead to coma or even death. This phenomenon has been referred to as "automatism." It is advisable, therefore, not to keep a prescription containing barbiturates (or any other sedative-hypnotic) on the nightstand next to the bed. Instead, the drugs should be kept in the medicine cabinet so that the individual must get out of bed for them so that he is more likely to be aware of what he is doing.

Another important point to be mentioned here is that of ingesting barbiturates and alcohol. It can be said with certainty that the depressant effects of barbiturates (as well as any other sedative-hypnotic or tranquilizer) will be in-

tensified by the ingestion of alcohol. In other words, there is a greater than additive effect of barbiturates and alcohol on the central nervous system. This is termed "potentiation" or "synergism." Even mild to moderate consumption of alcohol while taking prescribed "or abused" barbiturates might be sufficient to cause motor incoordination, drowsiness, confusion, and even coma and death.

Although physical dependence does not develop with the dosages normally used in medical practice, it does occur with the excessive doses used by drug abusers. A tolerance is also developed. Withdrawal symptoms usually are exceedingly dangerous and can cause death.

Within the first 12 to 17 hours after the barbiturate is withdrawn, the levels of the drug in the body decrease and the person may even seem to improve, but then he becomes increasingly restless, anxious, and weak with a pronounced trembling of the arms and legs. There may be complaints of abdominal cramps, nausea and vomiting. Fainting may occur if the person is lying or sitting down and then quickly stands up. Within the first 24 hours of withdrawal he may be too weak to get out of bed. Coarse tremors of the hands are prominent. During this period the patient may plead for his drug. With most barbiturates, the symptoms usually reach a peak within the second or third day after withdrawal. It is during this time that convulsions may occur. This effect is by far the most dangerous sympton. With certain of the long-acting barbiturates, such as phenobarbital, symptoms of withdrawal peak more slowly and seizures may occur as late as the seventh or eighth day after withdrawal has begun. During this time anxiety mounts and visual hallucinations, disorientation as to time and place, and delirium may occur.

Barbiturate withdrawal differs in several respects from narcotic withdrawal. In narcotic withdrawal such effects as runny eyes, intestinal spasms and diarrhea are more pronounced, and muscle incoordination is not usually seen as it is with barbiturate withdrawal. In contrast to the barbiturates true convulsions are not seen in withdrawal from narcotics. This is the major difference between these two types of withdrawal. For this reason, many experts state that withdrawal from barbiturates is more dangerous.

Barbiturates are known to drug abusers as "barbs," "candy," "goof balls," "sleeping pills," or "peanuts." Specific types are often named after their color or shape. For example, pentobarbital sodium in solid yellow capsule form is known by abusers as "yellow jackets" or "nimbies" (after a trade name of this drug). Secobarbital sodium in red capsule form is called "reds," "pinks," "red birds," "red devils," and "seccy" (also after a trade name). Amobarbital sodium in solid blue capsule form is known by abusers as "blues," "blue birds," "blue devils," or "blue heavens." Amobarbital sodium combined with secobarbital sodium in red and blue capsule form is known as "rainbows," "red and blues," or "double trouble."

Barbituric acid, which is not a depressant, is the chemical from which all the barbiturates marketed today are derived. It was first prepared in Belgium in the 1860's. Barbital, the first barbiturate to be used medically, was introduced in 1903. Phenobarbital, the second oldest barbiturate, followed in 1912. A large number of others followed in quick succession. The short-acting barbiturates, especially pentobarbital, secobarbital, and amobarbital, came into wide-spread use within the last 20 to 30 years. Of all the barbiturates currently on the market, phenobarbital is still the most widely used barbiturate in medicine.

The numerous varieties of barbiturates differ in the amount of drug and in the time necessary to produce the various stages of depression. Because of these differences and for the sake of convenience, investigators and authors have classified the barbiturates on the basis of length of onset of action and duration of action, *i.e.*, long, intermediate, short, and ultra short. People who abuse barbiturates want immediate effects from the drugs. Thus, barbiturates with a short onset are more abused because the desired effects are reached more quickly. If these drugs are injected the onset time is decreased even more.

The barbiturates are considered to be general depressants. This means they are capable of depressing or inhibiting the normal activity of nerves, skeletal muscles, smooth muscles (*i.e.*, muscle found in the gastrointestinal tract and blood vessels), and heart muscles. Obviously these drugs will depress a wide range of body functions. In individuals with acute barbiturate poisoning, actions on the heart and blood vessels represent a major problem. The central nervous system is very sensitive to the effects of barbiturates so that when they are given in sedative doses, actions on other parts of the body are negligible. Therefore, such effects as drowsiness, incoordination, euphoria, sedation, sleep, and even coma are all due to the effects of barbiturates on certain areas of

the brain. The precise mechanism by which barbiturates cause their depressant or inhibitory effects on the brain is not known.

The dependence-producing qualities of the barbiturates were not immediately recognized, but they have become increasingly clear since 1940. Virtually all barbiturate addiction begins with a psychological dependence. The frequent barbiturate user may continue for sometime taking sedative doses of a barbiturate. On a given day he may decide to take an extra quantity of barbiturate capsules more times than usual. He finds that he is pleasantly surprised by the result. He likes the feeling that these extra capsules have provided. It can be said that he has been *positively reinforced* by the drug.

Drugs may also produce effects that might be considered undesirable. Such drugs would then be referred to as *negative reinforcers.* Since the typical dependence-prone person enjoys the feeling provided by extra capsules he continues to maintain this increased dosage level. Within a few days he feels that he "needs" the extra pills to get through the day. He feels that the effects produced by the drug are necessary to maintain what he believes is his best state of well-being. It might be said that this man is *psychologically dependent* on the barbiturate. Eventually, he finds that the small increase of dosage does not provide the effect he is seeking. He must then increase his daily consumption of the barbiturate to obtain the desired effect. This phenomenon is known as *tolerance.* The man soon discovers that he must be under the influence of a barbiturate all day, every day, or he becomes restless, anxious, and very weak. He has now graduated to the level of *physical dependence.* This is a state in which there has been an actual change in the physiology of the body so that the individual actually does need the drug to function "normally." If the drug is stopped or removed, a withdrawal or abstinence syndrome is observed. The man is now both psychologically and physically dependent on barbiturates. Any other barbiturate, or most of the other marketed drugs classified as sedative-hypnotics, will prevent withdrawal symptoms if the person cannot get the particular barbiturate he has been taking. This phenomenon is called *cross-dependence.*

It is easy to understand why certain persons may become dependent on barbiturates. Sedative or sleep-producing doses of barbiturates produce a mild state of euphoria. This sense of well-being might be compared to the "high" feeling that one obtains after consuming a quantity of alcohol. It is this high feeling that the barbiturate abuser is seeking. Tolerance to the euphoria will occur with time. Since this is the sensation that the abuser is seeking he will increase the dose to obtain this effect.

It cannot be stated with certainty who will abuse barbiturates, since this form of drug abuse, in general, cuts across every economic and social strata. Abuse of barbiturates also occurs at all age levels. It is seen in junior high schools, high schools, colleges and among the general population from small towns to large cities.

Many people seek the sedative-hypnotic effects of barbiturates in order to cope with periods of anxiety and tension or emotional distress. The sedative effects combined with the euphoria which is produced allow these people to "escape." Such people may view the pressures of daily living in a competitive world so frightening and alarming that they use barbiturates as a means of escape. This, incidentally, is also the reason given by many of the college and high school students. They state that there is so much pressure to succeed, to get good grades, and to obtain good jobs, that their lives become almost unbearable.

Other people take barbiturates to counteract the effects of stimulants (such as amphetamines). These people are often on a cycle of taking amphetamines during the day for "stimulation" (and also the euphoria which these drugs produce), and then taking barbiturates at night to sleep.

The most predominant reason given by most high school and junior high school students for abusing barbiturates is pressures from their peers. To take drugs means "belonging," to be a part of the "in crowd." In many instances, even though a young person does not wish to take the drugs he is pressured into it by "friends." Another reason given for taking barbiturates is curiosity. Young persons have heard about the effects of barbiturates and they want to see if the claims are true. Many state that they take drugs as a means of rebelling, or just for "kicks."

Generally it is quite difficult to identify the barbiturate abuser since many of the drug's effects can be produced by many other conditions which are not associated with the abuse of drugs. For example, one of the most common side effects in barbiturate abuse is drowsiness. There are, however, many medications which produce this condition including some of the most common over-the-counter cold rem-

edies. Generally speaking, the most important characteristics with respect to barbiturate abuse are changes in the behavior or attitudes of the individual which are different from those of the past. These may include: a sudden and dramatic change in work or school attendance, personal discipline, and academic inactivity, unusual flare-ups or outbursts of temper; unusual inactivity; finding the person in odd places during the day (such as closets and storerooms for the purpose of taking drugs); borrowing or stealing money or other small objects which can be readily converted to cash (to finance drug purchases). However, even these statements are often too conjectural because drug abuse may be only one reason for the observed changes.

In addition to the general changes listed, barbiturates may produce more specific indications of abuse. When under the influence of barbiturates, a person may manifest symptoms of alcohol intoxication but without the characteristic odor. However, an unsteady gait and speech problems may also be signs of neurological disorders. The person may be confused, incoordinated, and irritable. However, once again, these symptoms may be entirely unrelated to barbiturate abuse.

Figures on the abuse of barbiturates are difficult to obtain. It can, however, be stated with certainty that use of barbiturates among students and the general population is increasing. Unfortunately the vast majority of studies performed to determine the incidence of abuse only consider the student segment of the abuse population. Drug authorities are unanimous in the view that barbiturate abuse is wide-spread among adults, but no satisfactory studies have been performed to determine the extent of such abuse.

Non-barbiturate Sedatives

In addition to barbiturates there are a number of other depressants which have historically been the subject of abuse. In the 1850's, modern chemistry opened a new chapter with the introduction of bromides as sedatives. With use, however, came misuse and abuse which often resulted in intoxication and psychotic or delerious complications. The bromide problem began to abate in the 1930's but only because the compounds were replaced by other sedatives, primarily the barbiturates.

In the 1950's a new class of drugs, the so-called minor tranquilizers, began to appear. They have a barbiturate-like action and can produce both psychological and physical dependence. They quickly enjoyed wide-spread use, found their way to the black market, and have been abused in much the same manner as the barbiturates.

Additionally there are a large number of non-prescription sleep aids which have recently become a source of drug abuse. These products contain antihistamines, scopolamine, and bromide salts. In the quantities present in typical formulations the ingredients cause a low level of central nervous system depression or sedation that lay claim to providing "natural sleep," relief of simple nervous tension," and other tranquil conditions.

The antihistamines constitute a large group of synthetic organic compounds used in the treatment of respiratory conditions, allergic skin rash and other forms of allergies. In some cases they may cause side effects unrealed to the purpose for which they were originally intended. Sedation and drowsiness appear to be the most common. It is on the basis of this side effect that the antihistamines are contained in the non-prescription sleep aids.

Excessive dosage of these antihistamine preparations cause extreme drowsiness followed by nervousness, tremors, muscle twitching, delirium, and convulsions. Respiratory depression may be very marked with an accompanying cyanosis and fever. Unconsciousness may follow quickly, or be delayed. Death has occurred following overdosage within 1 to 24 hours.

Scopolamine or hyoscine, is an alkaloid which is derived from a natural plant, called Datura or balladonna. The drug acts on certain cells in the viscera to prevent spasms. Another action is to depress brain activity. This action is prompt. At first the patient feels drowsy and apathetic. Sleep ensues and lasts for several hours. The depressed psychic state may be preceded by a period of excitation, hallucination, and disorientation. Other possible side effects of scopolamine salts include blurred vision, rapid pulse, dizziness, and dryness of the mouth.

Scopolamine is used principally to produce its sedative effects on the brain. It is frequently given with morphine since it is believed to potentiate the action of morphine on the brain. The effect produced is often referred to as "twilight sleep." The drug combination produces a blurred consciousness in which pain is not completely obliterated but is made less poignant. The mental ability of the patient is

impaired from reproducing in consciousness the events which occurred during twilight sleep. Scopolamine is frequently administered to expectant mothers to alleviate labor pains preceding child birth.

Another group of non-prescription sleep aids contains the inorganic bromides ammonium, potassium and sodium. The main action, which is due to the bromide ion, is one of depression of the central nervous system. This depression is characterized by a pronounced feeling of lassitude, unconcern, and aloofness. Mental alacrity is depressed, concentration is impaired, and mental confusion may result.

Ingestion of bromides over extended periods of time may give rise to a variety of untoward effects. Gastrointestinal irritations is often encountered. Fetid breath, brown furred tongue, constipation, and flatulence may follow in the wake of the gastrointestinal disorder. In other cases, there may be a characteristic infection of the conjunctiva accompanied by excess production of tears, along with cold or hayfever-like symptoms and excessive salivation. A characteristic rash not unlike acne may also appear.

With excessive dosages of bromide-containing preparations, the following symptoms have been noted: drowsiness, depression of intellectual powers, slurring of speech, an unsteady gait, and a generalized clouding of consciousness. Marked changes in personality pattern have also been noted.

LSD - 25 (Lysergic Acid Diethylamide)

The best known hallucinogenic drug is D-Lysergic Acid Diethylamide Tartrate (LSD-25). It is most frequently referred to simply as "LSD." The common drug jargon reference to it is "acid." LSD is derived from the ergot fungus, a disease which generally grows as a rust on rye grain and other cereals. It was first developed in 1938 from one of the ergot alkaloids. Although its hallucinogenic properties were not discovered until 1943. It can be found as a liquid or a powder. When processed, LSD is colorless, odorless and tasteless. A dose of 50 to 200 micrograms (which can be thought of as a dot no larger than the point of a pin) will take the user on a "trip" for approximately 8 to 16 hours. An effective dose may consist of less than 25 micrograms. It is so powerful that a single ounce is enough to provide 300,000 average doses. Users take it in capsule form or in a sugar cube, cracker, or cookie, or they can lick it off a stamp or other object impregnated with the drug. Frequently the drug has been soaked into clothing such as blouses and sweaters. Thus, it is possible to "take a trip" merely by licking an envelope or stamp, chewing on one's LSD-soaked clothing.

Physical reactions may include dilated pupils, lowered temperature, "goose flesh," shivering, chills, profound perspiration, increased blood sugar, rapid heart beat, a flushed face or paleness, irregular breathing, nausea, and loss of appetite. It is noted that the dilation of the pupils caused by the drug results in an LSD-induced photophobia (which is why users have been noted to wear sunglasses at night). Lethal overdosage has not been reported in humans. During the first hour after ingestion, the user may experience visual changes followed by extreme changes in mood. In the hallucinatory state, the user may suffer loss of depth and time perception accompanied by distortions with respect to size of objects, movements, color, spatial arrangement, sound, touch, and his own "body image." During this period, the user's ability to perceive objects through the senses, to make sensible judgments, and to see common dangers is lessened and distorted, hence making him susceptible to personal injury. He may also injure others in the event he decides to drive a car. There are many reports on record where individuals after using LSD believed that they were immune from injury. Severe injuries commonly result from such follies as attempting to walk on broken glass and to touch fire. Another frequent example of altered perception is the belief that one is able to fly. The user believes that he has been transformed into a bird or butterfly and then plunges to his death in his attempt to become airborne.

The first effects, usually reported by LSD users, involve sudden changes in their physical senses. Walls may appear to move; colors seem stronger and more brilliant. Users are likely to "see" unusual patterns unfolding before them. Flat objects seem to stand out in three dimensions. Taste, smell, hearing and touch seem more acute. One sensory impression may be translated or merged into another; for example, music may appear as a color, or colors may seem to have taste.

One of the most confusing yet common reactions among users is the feeling of two strong and opposite emotions at the same time —they can feel both happy and sad at once or relaxed and tense — one's arms may be both heavy and light at the same time.

Effects can be variated at different times in the same individual. Researchers have found that even in carefully controlled studies responses to the drug cannot be predicted. For this reason, users refer to "good trips" and "bad trips" to describe their experiences.

Among LSD's other effects on the user is the loss of his sense of time. He is unaware of how much time is passing (although he does remain conscious throughout the drug experience.)

Perhaps the LSD trip is best explained by one who has experienced it. The following observations are those of Lambert Dolphin, Jr., of the Stanford Research Institute in Palo Alto, California. Dolphin reports that shortly after taking LSD,

> ". . . I began to experience heightened audio and visual perception. Background music became ecstatically alive and full of richness. The musical instruments became spacially deep and vividly alive inside of me. Vivid color patterns and fantasies in three dimensions filled my mind when I closed my eyes, and with open eyes I perceived the objects in the room with amazing depth, clarity, and a shimmering, crystalline glow. Gradually I lost awareness of my body and seemed to be pulled ever deeper downward into the past and into myself. Strange emotional experiences and long-forgotten dreams bubbled up inside.
>
> "I had the feeling that I was outside myself, looking into thousands of corridors of my life as if I were a whole universe in miniature. At times I seemed to be a vast cathedral. I was aware of history and the past as neither gone or inaccessible. Time became strangely distorted and I even experienced the terrible sensation of time stoppage and endless eternity.
>
> "Unpleasant and terrible fears associated with conception, birth, and early childhood ripped my mind and for painfully long periods of time I was caught up in closed cycles of temporary insanity and terrible vast worlds of unreality. The environment around me became strangely alive and hauntingly familiar.
>
> "Strange forces and powers seemed to seethe about me, calling and pulling at my soul. I was aware of the remoteness of God who seemed far off and inaccessible. It did not occur to me to pray. Instead I wondered who I was and how I would ever find myself."

Scientists report that the LSD user can reason logically, up to a point, while undergoing the drug's effects. He usually remembers after the drug wears off much of what happened to him. He may, for example, have become fascinated with an object in the room, like a chair or vase. On larger doses he may feel mystical and report a sense of rebirth or new insights. Frequently, bizarre observations such as "seeing" blood course through one's veins will reappear in the mind with unusual clarity. But the LSD tripper is often unable to explain his experience to others. Many medical authorities feel that chronic or continued use of LSD changes values and impairs the user's powers of concentration and ability to think. This may lead to a tendency to "drop out" of society as urged by Timothy Leary.

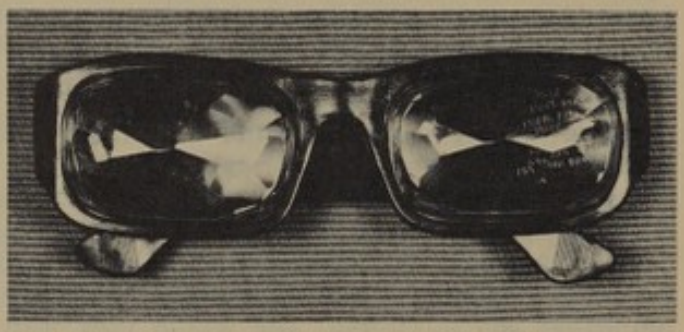
Occasionally there may be a loss of insight into the drug induced patterns of sensations felt during the LSD experience. Paranoid delusions may occur about other people in the environment who are believed to be trying to harm or kill the subject. Intense self-loathing with suicidal impulses or great feelings of mystical revelation can also occur. The exact quality, nature, and content of these experiences appear to depend in a complex manner on the personality and expectations of the subject, the dose of the drug, and the setting in which the drug is administered.

There has been intense scientific interest in the possibility that LSD may reproduce naturally occurring schizophrenic states. After more than 20 years of research, it seems most sensible to hypothesis that LSD can produce a state which is similar but not identical to naturally occurring schizophrenia, and which may also resemble the toxic deliria caused by other agents such as atropine or scopolamine. Because of the assumed similarities of the state produced by LSD and psychologically similar drugs such as psilocybin and mescaline to schizophrenia they have been termed "psychotemetics" or mimickers of psychosis.

An example of the possibility that use of LSD may cause a schizophrenic state is the recent, notorious case of Charles Watson, aged 25. On September 2, 1971 he testified in state court in Los Angeles, California that he participated in the fatal stabbing of Leno and Rosemary La Bianca on August 9, 1969 the day after he took part in the shooting and stabbing murders of four other persons in the home of actress Sharon Tate. According to Watson he acted on the orders of Charles Manson, head of their hippie clan. Watson said he had been taking LSD prior to the La Bianca killings. Manson and three women were tried and convicted earlier and have been sentenced to death.

After the typical "trip" the user may suffer acute anxiety or depression for a variable period of time. Recurrences of hallucinations or "flashes" have been reported days, or months after the last dose. Recurrences may occur with full intensity and unpredictability. All of the original side effects of a bad experience may recur for as long as up to 18 months after LSD ingestion. These events may have their onset during stress or when there has been no apparent stress whatsoever. Psychoses both short and long-range have followed the use of LSD for some. It is not yet known whether the drug causes the illness or merely precipitates it.

Regular use of LSD does not lead to physical addiction, but if the experience is pleasant to the user a certain psychological dependence may develop. It is possible, too, that the regular user may build up a tolerance to the drug—wherein regular doses produce lesser effects or no effect at all, thus necessitating an increase in the amount consumed.



Multi-faceted eye glasses are worn to produce tremendous light distortions which heighten the effects of certain hallucinogenic drugs such as LSD.

Currently, considerable research is under way to determine LSD's action on the body and nervous system. At the present time, its precise effects are not yet understood. Recently, independent experiments with animals have shown that LSD may cause central nervous system malfunctions. Several research groups have already demonstrated a strong possibility that LSD may produce chromosomal damage. Experimentation is also being conducted currently by licensed researchers on alcoholics and mentally disturbed persons to determine if the drug holds any therapeutic benefits. There is also a possibility that LSD may be of some use in alleviating the misery and depression of terminal cancer patients.

Much of the research on LSD has been of questionable validity because of the personal involvement of the researchers. Rather than being the subject of careful scientific inquiry, LSD has been invested with an aura of magic, offering creativity to the uninspired, "kicks" to the jaded, emotional warmth to the cold and inhibited and total personality reconstruction to the alcoholic or the psychotherapy-resistant chronic neurotic. On the West Coast, the effects are judged by some to be related to the insights of Zen Buddhism; on the East Coast, they are judged by new and free social order.

The therapeutic uses of LSD have been pioneered by leading psychiatrists in many instances, including Abramson, Frederking, Osmond, Savage, and Sandison. With much of the published work, however, there is an implicit or explicit attitude that the self-knowledge of the leverage for self-change allegedly produced by LSD may be of value or benefit to individuals who do not ordinarily consider themselves mentally ill. At the extreme of this attitude-dimension is the International Foundation for Inner Freedom, formed by two psychologists, Drs. Leary and Alpert, who claim that LSD and other psychedelics should not be considered drugs at all but should be classed with poetry, music, literature, and art, and should be available to all men wishing to improve their minds and "expand their consciousness."

Some users believe that LSD can heighten their senses and help to make them more creative. But studies of paintings, writings, and other works produced by users of the drug have failed to support this viewpoint. In many cases works performed by people after they used LSD appeared to be noticeably poorer than before. In a typical experiment a person will be asked to draw the same object several times following repeated dosages of LSD. The drawings produced by the subject normally are less complete, less perceptive, and more infantile. Eventually the object drawn is unrecognizable in the picture.

Exactly how LSD works in the body is not yet known. But it seems to affect the levels of certain chemicals in the brain and to produce changes in the brain's electric activity.

Animal experiments with LSD suggest that the brain's normal filtering and screening-out process becomes blocked, causing the brain to become flooded with unselected sights and sounds.

Studies of chronic LSD users indicate that they continue to suffer from an overload of

stimulation to their senses. Researchers believe this may explain the regular user's inability to think clearly and to concentrate on a goal.

A single or a series of LSD experiences can produce a psychotic break presumably by releasing overwhelming conflictual material which cannot be handled by the subject's established defenses. It is possible that LSD disrupts psychic homeostatic mechanisms and permits reinforcement of latent delusional or paranoid ideas. Probably, this occurs when the normal aversive and critical functions of the ego are impaired under LSD.

Since the government has taken steps to curb the illegal traffic in lysergic acid and lysergic acid diethylamide, drug abusers in the United States are using LSD of untested purity and strength. Use of bootleg LSD peddled to the abuser in various dosage forms of uncertain quantity and purity may add another hazard to the use of the drug.

It should not, however, be concluded that LSD is a difficult drug to produce. To the contrary, an expert chemist can synthesize it quite easily. Substantial quantities can be produced from equipment costing less than $1,000. The effects of LSD are potentiated by stimulants and some types of psychedellics. More and more young people have begun to use LSD and marihuana together for these effects, which tend to be counteracted by sedatives and tranquilizers. Reasons given by users for taking LSD included the usual reasons given in virtually all varieties of drugs. These included "curiosity," "kicks," "self-understanding," "rebellion," and other rationales usually identified with naivete and a fervor for exploration. An additional reason sometimes given in the case of LSD is the quest for religious or philosophical insights. The use of psychotropic drugs in the search for revellations and increased understanding of the universe is as old as mankind. At various times in history, substances as diverse as alcohol, ether, opium, and nitrous oxide (laughing gas) have also been claimed capable of providing an easy and instant path to wisdom or to religious or philosophical insights. Today these "conscience expanders" of earlier days are regarded as merely common place substances without any mystical properties whatsoever.

Recent surveys and hospital reports show that the drug's popularity may be declining, at least in some areas of the country, as its potential ill-effects become better known. It is believed that the decline of interest in LSD among drug abusers is due, in large part, to drug education efforts which have reported a link between LSD use and birth defects and other ill-effects produced by "bad trips" such as suicidal impulses and paranoia.

At this writing research continues on LSD. The National Institute of Mental Health is the primary federal agency for supporting and overseeing research on LSD. The single legitimate manufacturer of the drug, Sandoz Laboratories, discontinued production of LSD early in 1966, and turned over all existing supplies of the drug to NIMH. Today the institute possesses the only legal supply of the drug in the United States. The NIMH Center for Studies of Narcotic and Drug Abuse is currently supporting 58 research projects which include surveys of the extent of the use of LSD by students and the general population; LSD's biological, psychological, and genetic effects in animals and humans; basic studies to explain the drug's action and to chart its course in the body; and long-range projects to study LSD users and their culture.

Special emphasis is being given to determine methods of treating acute episodes of LSD reaction. Presently such reactions are treated simply by restraining the person and preventing him from harming himself or others. Interpersonal rather than mechanical restraint is usually effective. Tranquilizers are also used, particularly chlorpromazine (Thorazine) which is usually but not always effective when used in various doses. Barbiturates have also been employed with some success. In the acute stages, psychiatric support is generally based upon reassurance that the effects will wear off. The patient is encouraged to relax and not fight to differentiate which of his perceptions are accurate and which are drug-distorted. As LSD guides or "sitters" say, "flow with it, don't fight it."

Considerable research is also being done on the effects of LSD on every day tasks such as driving an automobile. Dr. George E. Woody has already suggested that hallucinogens like LSD may have after-effects that include recurrent visual disturbances. This characteristic is not shared by alcohol, barbiturates or other drugs which have already been established as driving hazards. In a communication to the American Journal of Psychiatry, Dr. Woody related three case histories of young LSD users who suffered visual disturbances while driving and came close to having an accident as a result. None had taken LSD for some time prior to the incident. One subject reported slam-

ming on his brakes after imagining a huge pink and blue tea cup appeared in the road before him. Only time will tell what other hazards may be in the wake of LSD use.

Peyote and Mescaline

Peyote refers to a number of cactus plants containing pharmacologically active substances of a hallucinogenic nature. The most important agent obtained from the cactus is the alkaloid, and mescaline. Mescaline is found along with other alkaloids in peyote (mescal) which is obtained from the dumpling cactus (Lophophora Williamson), a small carrot-shaped spineless cactus which, in the United States, grows in the Rio Grande Valley, and in the arid regions of Mexico. The plant grows mainly underground, but above the earth one finds the source of the drug, an unconspicuous group of button-shaped growths. As mentioned earlier the top of a plant is cut off and dried in the sun to form the peyote buttons, which are used by various Indian tribes in Central America and in the southwestern regions of the United States.

Peyote is not a physically addicting drug. There is no evidence that abstinence symptoms occurs when the drug is not available. However, like LSD, it may produce psychological dependence. Interest in mescaline, or peyote, centers on the fact that it causes unusual psychic effects and visual hallucinations. A dose of 350 to 500 milligrams of mescaline produce illusions and hallucinations for five to twelve hours. In some respects, the psychic changes are similar to those caused by minute doses of LSD.

Peyote usually appears as dry, leather-like buttons cut from the cactus plant of the same name. The buttons may be chopped or ground and placed in gelatin capsules or rolled into balls. Peyote may also appear in liquid multiple dose vials, although this is rare. Its derivative mescaline usally appears as a crystalline powder often mauve in color, in variously sized gelatin capsules or more rarely, as a liquid in ampules or vials.

As is the case with all illicit drugs purchased on the street, constant danger stems from a lack of knowledge on the user's part, concerning the purity and strength of the drug he is taking. Mescaline for instance, may be mixed with LSD, amphetamines, or PCP (the so-called "Peace Pill"), a powerful animal tranquilizer. Such combinations may produce severe damage to the central nervous system in humans. Samples of mescaline analyzed in laboratories very frequently turn out to be LSD, and usually "bad" or chemically incomplete LSD at that.

The changes in visual perception induced by mescaline are not always pleasant. Aldous Huxley entitled one of his books *Heaven and Hell* in recognition of the conflicting sensations induced by the drug. The "hellish" experiences include an impression of blackness accompanied by a feeling of gloom and isolation, a garish modification of the glowing colors observed in the "heavenly" phase, a sense of sickly pale greens and ugly dark reds. The subject's perception of his own body may become unreal: his limbs may seem to be distorted, or his flesh to be decaying; in a mirror his face may appear to be a mask, his smile a meaningless grimace. Sometimes all human movements appear to be mere puppetry, or everyone seems to be dead.

These experiences can be so disturbing that a residue of fear and depression persists after the effects of the drug have worn off. There have been reports of persons reaching severe states of desperation with suicidal fantasies and yet unable to seek help because of paranoid delusions of persecution.

There is almost always initial nausea, with or without vomiting accompanied by a dilation of the pupils and a generalized increase of perspiration. This is followed by a general slowing down of motor responses and slow speech. With a few exceptions the appetite for food and sex stimulation seem greatly reduced.

Under the influence of these drugs, the distinction between subjects and objects may be altered. Loss of personal identity in the extreme cases may produce paranoid reactions for the person who is no longer able to distinguish between exterior ideas and those which originate in his own mind.

The "bad trip" or "freak-out" occurs when the user loses control and is flooded with intense anxiety, fearful visual and tactile hallucinations, suspiciousness, paranoid illusions, intense depresson or a sense of losing his mind. Initially, the mescaline tripper may attempt to control these feelings himself by concentrating on pleasant exterior stimuli, such as paintings or music, talking to friends or taking "downers" (sedatives and tranquilizers) which are sold on the street for this business.

Among some individuals one of the most important constancies in perception is affected; the distinction between subject and object, a warm sense of personal security depends on

knowing accurately the borders of their self and on being able to distinguish what is inside and what is outside. Paranoia is the most vivid pathological instance of the break-down of this discrimination; the paranoia attributes to personal and impersonal forces outside himself, the impulses are actually inside him.

David S. Flattery and J. M. Pierce in their book, *Peyote* describe the case of a young woman:

> ". . . who had previously taken pride in her mental solidity, and apparently [while under the influence of the drug], the sensation of diminished control of her mind and body were terrifying. Within two hours she was writhing miserably with various somatic discomforts and shivering uncontrollably. Every large stimulus sent her into paroxysms of fright, and she began to misinterpret statements in a paranoid manner. Several months later she entered into psychotherapy and the peyote experience was mentioned as one of the precipitating stresses."

Among the after-effects described by subjects, many have been left with a listlessness attributable to their hardened impression that most of their daily activity is a useless farce. Ambition is now seen as somehow fraudulent and accomplishing the business of the world now seems less important than previously. These same people may also note a physical component to their apathy that prevents them from becoming active.

There is a possibility that the drug may be dangerous for pregnant women. Certainly the expectant mother should abstain from all unnecessary drug use. Dr. William F. Gaber at the medical college of Georgia working with hamsters tested injections of mescaline in pregnant females. The study showed that only 62% of the fetuses were normal. Approximately 28% were found to bear congenital abnormalities. The remaining 10% were found to be either dead or severely runted. The price of peyote is extremely variable and depends upon where it is bought.

In Texas, peyote can be purchased for 1¢ per button or 10¢ for 100 buttons. It can be sold in Los Angeles for $1.00 for 4 buttons, or it can be bought in plastic sandwich bags which contain about 25 buttons for $10.00. In New York, 10 buttons sell for $2.00 to $5.00 and a ten pound bag containing 10 to 15 plants might sell for about $200.00. A "full moon" (a button approximately four inches in diameter) sells for $3.00 to $4.00. The price of peyote in Chicago is only slightly less than that which it commands in New York. Illinois law enforcement officers, however, report that traffic in the drug is extremely light and peyote buttons are encountered only on very rare occasions.

The price of mescaline also varies substantially depending upon locations. The most common price reported is $5.00 per capsule. Variations have been encountered, however, from 50¢ per capsule in New York to $7.00 per capsule in Miami. The current price for mescaline in Chicago is $5.00 per capsule. This is equivalent to 300 milligrams. Illinois officials report, however, that true mescaline is extremely rare. In virtually all cases, what is sold as mescaline is, in fact, LSD or some other psychedelic drug. A recent sale of mescaline was, however, reported in Skokie, Illinois.

Peyote is almost always taken orally. Users have devised many ways to avoid its gritty, bitter taste which often induces nausea, gagging, and difficult swallowing. In party settings the buttons, either whole or chopped, are often brewed with tea, and then the peyote tea is drunk. For a more intense effect, the cooked buttons are chewed while the tea is sipped slowly. It is also common for persons to drink tea, coffee, wine, or even milk while chewing the peyote to help avoid the bad taste. There are rare instances on record where subjects have reported "shooting" a liquid concoction of peyote intravenously.

In the case of mescaline, the capsule is usually swallowed, but it may also be taken with hot orange juice or hot cocoa. "Skin popping" (subcutaneous of intramuscular injections) and "sniffing" the drug have also been reported.

Peyote is often referred to as "button," "tops," "moon," "cactus," "the bad seed," or simply as "P,". Mescaline is usually referred to by its proper name The only two nicknames which have been reported are "mesc" and "Big Chief".

Peyote and mescaline are sometimes used in combination with other drugs such as marihuana and LSD. In general, research subjects claimed that the marihuana helps produce a "greater relaxation," a greater performance, a decrease of nausea, and accentuation of the more pleasant effects produced by the hallucinogenic agents.

Opinions differ about the effects produced by narcotic drugs used in conjunction with hallucinogenics such as mescalne. Some claim that heroin does not "mix" with these drugs and that the combination tends to make a person sick.

Others have used heroin and other opiates "to level off their experience," to enable them to go to sleep, to become more "earth bound" and to "achieve a slower drift."

One subject has reported a very pleasant effect from the combination of mescaline and d-amphetamine tannate. Another has reported that glutithimide (Doriden) and barbiturates can be used successfully to diminish mescaline effects.

Concerning the various hallucinogenic effects themselves, it appears that they can be used interchangeably to produce similar effects. Although some research subjects have felt that they could distinguish these different substances from one another, for the most part various hallucinogenic agents tend to produce similar experiences and feelings in most individuals.

With regard to geography, the larger cities seem to provide the greatest ease of access to peyote and mescaline. Although peyote is "naturally available" in areas of Texas and Mexico, these specific areas are difficult to find and "contacts" are difficult to make. New York (especially Greenwich Village, Harlem, and lower Manhattan) is not only a source of supply for local residents but apparently is a major point of supply for other areas, especially Miami. The other East Coast city in which peyote and mescaline are reported to be readily available is Boston. Smaller amounts are available in Pittsburgh and Baltimore. As indicated previously the drugs are somewhat of a rarity in Chicago. On the West Coast, Los Angeles, San Francisco, and San Diego are centers where these drugs are available.

The source of supply, economics, and method of distribution of hallucinogenic drugs such as peyote and mescaline differ from those of the narcotic drugs. For example, it is not unusual for friends to share hallucinogenic drugs with each other. Frequently they are dispensed at parties much in the manner in which one might offer a guest an alcoholic drink. This is very rarely the case with narcotic drugs. When the hallucinogens are sold they are not sold through "narcotic pushers" but rather by individuals who deal mostly in stimulants, depressant drugs and marihuana. Sellers of hallucinogenic drugs, in fact, tend to look down on persons involved in narcotic drugs. Generally, the members of this latter group are known to be unreliable and treacherous. The hallucinogenic drug traffic is not considered to be as "cut throat" as is that of narcotic drugs (especially heroin). For the most part business dealings tend to be friendly and on a personal basis rather than purely for financial gain.

As mentioned previously, the "original" source of supply of peyote is in certain areas of Texas and Mexico. Enterprising drug users have acquired peyote from certain Indians in Mexico and from Mexican settlers and Indians in Texas. In their article "Patterns of Hallucinogenic Drug Abuse," Drs. Arnold M. Ludwig and Jerome Levine report that one of their patients of Mexican extraction claimed that his people viewed peyote as a religious drug and there were no real taboos on its use. Other patients were able to acquire the drug by simply ordering it from companies in Texas or purchasing it at certain grocery stores in New York City.

Mescaline, being a purified or manufactured substance, is not available "naturally". Drs. Ludwig and Levine report that some of their patients report that they had been able to order the drug directly from a pharmaceutical house or through local drug stores. These assertions, however, are quite dubious since there is no recognized medical useage for mescaline and its legitimate manufacture is legally prohibited. There are also reports that the drug is being synthesized by college students in New York and in the Boston area.

As mentioned above peyote and mescaline are not physically addicting, but may be psychologically addicting, particularly among persons who have a mental disorder. This is true because the psychedelic experience is more of an ordeal than a pleasure. Very little is known about the tolerance factor in peyote and mescaline. Divergent viewpoints exist. One mescaline user claims that the first experience tends to be the most intense and that the intensity diminishes somewhat with increased exposure to the drugs. Another group of research subjects have claimed that they can reach virtually the same "high" without increasing the amount of drugs taken. Several studies have indicated that "tolerance" works in reverse with these drugs in that a person becomes more susceptible or sensitive to their effects and, in time, can achieve the "high" on an even lower dosage. Of interest is the claim of some subjects that they could almost slip back on occasion into the same frame of mind even without taking the drug.

Psilocybin and Psilocyn

Psilocybin and Psilocyn are obtained from certain mushrooms generally grown in Mexico. They were first isolated in 1958 by Hoffman from

the fungus botanically known as *Psilocybe Mexicana Heim.* Like peyote, they have been used in Indian rites for centuries.

Their effects are similar to those of mescaline, except that a smaller dose of from four to eight milligrams is ample. The experience lasts for approximately six hours. Psilocybin and psilocyn do not produce physical dependence although users have been known to develop a tolerance to them.

Very little is known concerning the illegal use of these drugs because of their relatively recent discovery and because they are generally unavailable. For the most part the drugs are still unknown to many drug abusers. They may be obtained in either a crystalline, powder, or liquid form. When available, the price is reported to be similar to that commanded by LSD. There are no known nicknames for the drugs.

The sources of supply for psilocybin and psilocyn are not clear. These drugs seem to be available on a very sporadic and more limited basis than even mescaline or peyote.

DMT and DET

DMT (Dimethyltryptamine) is a short-acting hallucinogen found in the seeds of certain plants native to the West Indies and part of South America. The powdered seeds have been used for centuries as a snuff—called "Cohoba" —in religious ceremonies, to produce a state of mind which the Haitian natives claimed enabled them to communicate with their gods. It is also produced synthetically by clandestine chemists.

DMT is not taken orally, but its vapor is inhaled from the smoke given off by burning the ground seeds or powder mixed with tobacco, parsley leaves, or even marihuana. With proper preparation it can also be injected.

The effects of a single dose—60 to 150 milligrams—last only from 45 to 60 minutes. The effects are primarily hallucinogenic. It may cause psychological but not physical dependence.

DET (Diethyltryptamine) is chemically related to DMT but has not yet been found in plant life. However, it can be produced in a laboratory. In fact, a dose of 50 to 60 milligrams causes visual distortions, dizziness, and a vague sense of time. The experience may last from two to three hours. DET is usually taken by smoking it in a mixture of tobacco, tea, parsley, or marihuana.

Bufotenine

This drug, which is related chemically to DMT, is derived from the dried glandular secretions of certain toads as well as from the amanita fungus. It, too, can be prepared in a laboratory where it is known technically as 5-hydroxydimethyltryptomine.

Generally injected rather than taken orally, a dose of 15 milligrams will produce visual disturbances and alterations of time and distance perceptions. Bufotenine is also used as a snuff. Its symptoms appear almost immediately. It also has severe and stressful physical effects, especially on blood pressure.

Ibogaine

This drug is derived from the roots, bark, stem, and leaves of an African shrub. It was also used in primitive society. Natives were known to use the compound while stalking game to enable them to remain motionless for long periods of time while maintaining normal alertness. High doses reportedly cause excitement, intoxification, mental confusion, and hallucinations. Ibogaine can be made in a laboratory with considerable difficulty.

DOM or STP

Known popularly as "STP" this drug appeared on the psychedelic scene in the early spring of 1967. Articles in underground newspapers promoted its use, claiming STP to be stronger than LSD. The compound was identified by FDA chemists to be 4-methyl, 2, 5-dimethoxyamphetamine, or DOM. Little is known about its therapeutic, pharmacological or psychological effects. However, doses of one to three milligrams produce euphoria and doses of more than three milligrams can cause pronounced hallucinogenic effects lasting eight to ten hours. One of the approved research groups looking into the drug problem states that "STP" is almost 200 times more powerful than mescaline but only one tenth as potent as LSD. "STP" is not found in nature, but is synthesized in the laboratory and has appeared in illegal channels in tablet form.

PCP (Phencyclidine)

PCP or phencyclidine is a relative newcomer among illicitly used hallucinogenic drugs. It has been used for several years in small doses as a tranquilizer for animals. It has enjoyed

growing acceptance among halluncinogen users because it is somewhat less hazardous than LSD. It has seen particularly wide spread acceptance on the West Coast where it is known as the "peace pill." California authorities told the Commission during its tour that PCP began to appear on the market after allegations were first made concerning the genetic hazards of LSD. PCP appears in tablet, capsule, and powder form from clandestine laboratories and is also sold under the guise of synthetic marihuana (tetrahydrocannibinol). Frequently, unscrupulous drug dealers sell LSD to users with the assertion that it is in fact PCP. Subterfuges such as this are common in the illicit drug market.

Morning Glory Seeds

For centuries mankind has sought new experiences by deliberate ingestion of substances having mind altering properties. The early discovery of herbs or plants with the ability to alter perceptions or states of consciousness was entirely accidental and the search for such substances was conducted purely on a trial and error basis. It was soon learned that vegetable alkaloids contained in plants having such properties were responsible for the production of psychic phenomena. An impressive list of such plants, including cahobe, betel nut, muscari, soma, peyote, and the seed of the morning glory is now available as a result of scientific investigation. Apparently the ingestion of morning glory seeds represents nothing more than a new chapter in man's search for substances that will profoundly affect his thinking and his feeling.

Today several species of morning glory readily grow in the United States. These plants are all members of the bindweed family *(Convolvulaceae).* They have been used for centuries for their hallucinogenic effects. Common trade names on the abuse market for the seeds include "heavenly blues," "flying saucers," and "pearly gates."

Results of analyses of the seed components have shown that they contain amides of lysergic acid, d-isolysergic acid amide, chanclavine, and clymoclavine. Hence, the active principles are quite similar to LSD and about one tenth as potent. Three hundred heavenly blues seeds give comparable effects to about 2 to 300 micrograms of LSD.

Dr. Albert L. Ingram, Jr., of Pennsylvania State University has done considerable research on morning glory seed reaction. He has reported a number of cases where users have experienced reactions similar to those of LSD such as increased awareness of color.

In most cases the seeds are ingested after grinding them up more or less as the Indians did, by eating the seeds whole or by extracting the active principle chemically, using such toxic chemicals as wood alcohol. These seeds have also been used as a source of lysergic acid in the illicit manufacture of LSD in home laboratories.

Symptoms following ingestion include characteristic depersonalization, pseudo-hallucinations, a feeling of wonderment, self-transcendence and grandiose fantasies. These symptoms usually last for about 24 hours. For at least three weeks it is quite possible to slide into a dissociative state at frequent intervals. These dissociative states are most unpleasant and one might feel that he was going "crazy."

Suppliers of garden seeds have claimed to add a nauseating ingredient to render the oral administration of these seeds most distasteful.

Catnip

Thrill seekers have discovered another psychedellic substance in the form of catnip, *Nepeta cataria.* Catnip is available in pet stores in its natural leaf form which is smoked in cigarettes or in a pipe and as a liquid extract in an aerosol container, which is sprayed on tobacco and then smoked in any conventional manner. According to several users the effects of catnip are similar to those of marihuana. However, the recurrence of the state of altered consciousness suggests that the effects of catnip may be more like those of LSD than marihuana, and therefore may be more serious.

It has been reported that catnip sales have recently increased. Previously, pet store owners thought that a good week for catnip consisted of selling a dozen one ounce packages, but some dealers have been asked to supply 100 pounds at a time.

As indicated previously the Commission's Chief Counsel, Roger C. Nauert, purchased a packet of catnip from a California retailer as part of his continuing study of the youthful drug culture. The seller advertised the catnip as "legal hash." The word "hash" is an obvious reference to hashish. Recent research indicates that the seller's representations may be far more accurate than anyone supposed.

Nutmeg

Recently there have been reports of adverse effects occurring after the ingestion of nutmeg. It is believed that the effects are due to myristicin, a hallucinogenic component of nutmeg.

A reported case involved an individual who had previously taken LSD and cannabis with little or no effect. In contrast, four hours after having ingested one ounce of nutmeg in orange juice the following symptoms were noticed: the individual felt cold and shivery followed by severe vomiting, saw visions and the room appeared distorted with flashing lights, heard loud music, saw black creatures with red eyes, and felt as though he was being sucked into the ground. Vibrations and twitches in the limbs were noted. The mood was one of elation. After hospitalization the patient fell into a sound sleep. For the next week he felt as if he were walking on a cloud. Concentration was poor and lapses of attention were noticed. The most pronounced complaint from the patient was that of severe vomiting.

Glue Sniffing

The active components of airplane glue are toluene and related compounds, obtained from coal tar distillate. Chemically, toluene is known as methyl benzene or phenyl methane. It has a depressant action similar to that of barbiturates on the central nervous system. It can also cause severe damage to mucous membranes such as the cells of the nose, throat, and lungs. It also depresses the bone marrow, thereby causing aplastic anaemia (a very severe anaemia which is very difficult to treat) with repeated exposures. Fatalities have occurred after a single dose of 50 grams (inhaled) which is about the equivalent of a two ounce tube of pure toluene. Airplane glue or plastic cement as it is sometimes called is 80 per cent toluene.

The art of glue sniffing is sometimes called "flashing," and is usually carried out for its deliriant effects. Generally, the user squeezes some of the glue into a paper bag, holds the bag tightly over his nose and inhales the fumes. In the first stage these fumes induce a feeling of hazy euphoria something like that produced by alcohol. There soon follows a disordering of perception, double vision, ringing in the ears, and even hallucinations. The user's speech becomes slurred and he staggers about with poor coordination as if he were drunk. After 35 to 45 minutes, he falls into a state of drowsiness or stupor that lasts an hour and during which he is unable to recall what he is doing.

Occasionally sniffers erupt into violence or have delusions of grandeur, during which they lie on railroad tracks or think they can fly. Such impairment of judgment has resulted in serious or fatal episodes. Over-inhalation can result in kidney damage or even death. Illinois has not been spared from this latter phenomenon as can be seen in the mortality statistics published earlier in this Report.

Glue sniffing does not produce physical dependence. However, a form of psychic dependence can develop, and some users increase the amount sniffed each time to intensify their experience. Pharmacologically, the aromatic hydrocarbons in the glue act as a central nervous system depressant.

Glue sniffing was first reported in the United States in 1955. The 1960's brought a sharp upsurge. It is no longer sold separately from model kits. It is questionable, however, whether this precaution has done much to control its abuse. Some authorities feel that recent drug education efforts in the schools have been instrumental in reducing the substance's abuse.

Other deliriants also produce drowsiness, dizziness, and other effects comparable to that of airplane glue. They are usually solvents which make up the volatile substances contained in lighter fluid, paint thinner, and gasoline.

Airplane glue and the other deliriants are extremely toxic and can cause chronic mental confusion and coma, and sometimes death. In addition to the kidneys, the brain, bone marrow, and liver are vulnerable to damage from these substances.

Cough Preparations

A number of prescription and non-prescription cough preparations have been sources of abuse over the years. Some of these contain antihistamines. Any remarks concerning this group would duplicate the discussion of antihistamines contained in a prior section. Also, cough preparations containing codeine and similar ingredients are best thought of as quasi narcotics. In addition to their cough suppressing qualities they contain the usual risks associated with narcotics which have been discussed previously in Chapter 5.

Thus, the discussion of this section is confined to those cough preparations containing dextromethorphan. This is a common cough suppressant in the nonprescription cough remedies. Although it is chemically related to the

narcotic analgesic levorphanol tartrate, it does not possess analgesic or addicting properties. In recommended doses, dextromethorphan has few side effects. Rarely, dizziness and nausea have been noted.

Larger than recommended dosages of dextromethorphan-containing preparations may produce a central stimulating effect. Combined with high doses of antihistamines and decongestants the drug may give an effect which some individuals may think of as euphoric. In the methods with which drug abusers operate, combinations of one or more products seem to be a common vehicle to euphoria.

Motion Sickness Remedies

The term "motion sickness" is used to designate a syndrome of vertigo and nausea resulting from body motion. The symptoms of motion sickness vary in different individuals, but most frequently include drowsiness, pallor, cold, sweating, salivation, nausea and vomiting. Headache and vertigo may also be present.

Among the nonprescription compounds most commonly used to prevent motion sickness are included: dimenhydrinate hydrochloride, cyclizine hydrochloride, hyoscine hydrobromide, and carbohydrates. No untoward effects besides drowsiness are commonly noted from those preparations containing carbohydrates as the active ingredient.

More adverse reactions have been reported following administration of exaggerated doses of cyclizine hydrochloride. Within 30 minutes after ingesting 15 tablets (750 milligrams) of cyclizine hydrochloride, one individual being studied became euphoric and claimed to experience the feeling of having "transcended" every day problems. Several other persons noted these symptoms: irregular pulse, elevated blood pressure, exhilaration, disorientation, inability to perform simple calculations, deterioration of judgment, widely dilated and slowly reactive pupils, slurred speech, tremulousness, and incoordination. Hallucinations were noted in some of the cases, while convulsions were noted in others. Six hours later they experienced euphoria and tremulousness.

Asthma Remedies

Various powders and cigarettes used to relieve bronchial asthma have been abused by members of the drug culture. Such preparations consist mainly of the leaves of belladonna *(Atropa belladonna)* and stramonium *(Datura stramonium)*. They are intended to be burned with the smoke inhaled to relieve bronchial asthma. The main active ingredient of these plants are hyoscyamine and its isomers, atropine hyoscine.

The powder reportedly has been taken by abusers in various ways, including "spiked coffee," in beer or cola, or prepared as a "tea" and ingested orally. Also as many as four cigarettes have been smoked to produce the characteristic symptoms.

According to some observers, when these products containing hyoscyamine and atropine are abused, the toxic effects noted are similar to those of LSD. Both cause confusion, physical hallucinations, and disorientation. The pupils are dilated and both drugs cause hyperthermia and tachyardia. Anyone who has had the experience has described it as being decidedly unpleasant.

Caffeine

Caffeine, the active alkaloid of the coffee bean, tea, and cola seeds, is the main ingredient in stimulant preparations which are widely abused in the United States. Ingestion of above normal quantities of caffeine-containing beverages, or of large doses of products that contain caffeine may give rise to acute toxic reactions. These toxic reactions are characterized by vomiting and sometimes epigastric pain, vertigo and tinnitus. In severe poisonings the pupils of the eyes are constricted and nonreactive and there may be photophobia, a sensation of flickering before the eyes and restriction of the visual field. The patient is frightened, restless, and confused. He may suffer from headache, insomnia, tremors, delirium, and hallucinations, as well as from palpitation and oppression in the chest. The pulse is rapid and the blood pressure is lowered, the skin cold and clammy, the respiration is rapid and somewhat labored. There may be considerable diuresis, and the urine may contain sugar and acetone. Recovery from acute caffeine poisoning is usually prompt; fatalities are rare. Continued ingestion of large quantities of caffeine may lead to dyspepsia, headache, insomnia, listlessness, nervousness, confusion, tremors, neuralgia, sensory disturbances, and constipation.

Tobacco (Nicotine)

About 60 billion cigarettes are smoked annually in the United States alone. The acute

effects of tobacco smoking are largely due to the nicotine content. Next to caffeine, nicotine is the substance most widely used for its effect on mood.

In all the studies conducted by the United States Public Health Service on "smoking and health" a positive correlation has been observed between the incidence of lung cancer and cigarette smoking: approximately 11 cigarette smokers die from cancer of the lung for one non-smoker. Further correlation between the use of cigarettes and cancers of the oral cavity, larynx, and esophogus has been demonstrated. The rate of pulmonary emphysemia is also greater for chronic smokers. A clear relationship has also been established between the use of tobacco and various heart and circulatory diseases since it increases blood pressure and heart rate and, although there is no proof that use of tobacco causes arteriosclerosis or results in angina pectoris, the induced cardiovascular activity may trigger attacks.

Nasal, pharyngeal, and bronchial irritation may occur as a result not only of ingestion of nicotine but of the irritation from the many other constituants of tobacco or its smoke. Mucousal injury may result from these causes and from the heat generated in smoking. Tobacco use has also been linked with a gradual (or occasionally sudden) decrease in visual acuity.

As stated above, tobacco's effects are due largely to nicotine. Nicotine is an alkaloid which constitutes from 0.5 per cent to 8 per cent of tobacco, averaging about 1.5 per cent in cigarettes. It is one of the most potent drugs known and one of the most toxic, acting with a rapidity comparable to that of cyanamide. A single drop of nicotine is sufficient to kill a white rat instantly.

Although nicotine in the 19th Century was used in American medicine as an emetic, nauseant, expectorant and antiasthmatic, it now has no therapeutic applications. It acts on a variety of nerve cells and centers and has both stimulant and depressant stages of action. For example, it both increases and slows the heart rate; it affects arteries which can influence heart rate; it can cause changes in blood pressure; it can produce a hormone discharge which accelerates cardiac rate and raises blood pressure.

Nicotine markedly stimulates the central nervous system. Appropriate doses produce tremors in man and laboratory animals, in somewhat larger doses, the tremor is followed by convulsions. The excitation of respiration is a particularly prominent action of nicotine. Since stimulation of the central nervous system is followed by depression, death can result from failure of respiration due to both central paralysis and to a blockade of the muscles involved in respiration.

Nicotine is excreted from the body mainly in the liver secondarily in the kidney, lung, and milk of lactating women.

Poisoning may occur from accidental ingestion of insecticide sprays in which nicotine is present. It is said that the nicotine content of one cigar approximates two lethal doses for man, but swallowed in the form of tobacco, nicotine is much less toxic than would be anticipated. Apparently the gastric absorption of nicotine from tobacco taken by mouth is delayed so that vomiting removes much of the tobacco from the stomach.

Tolerance to nicotine develops when the compound is taken repeatedly, as is evidenced by the confirmed tobacco smokers who are unaffected by amounts of the alkaloid which would cause marked symptoms in the beginner.

Alcohol

Ethanol, sometimes called ethyl alcohol but most often referred to as alcohol, is a clear colorless liquid. Since it is a relatively small molecule, it easily passes through the tissues lining the mouth, stomach, and intestines by simple diffusion into the blood stream. If one were to simply rinse his mouth with an alcoholic beverage without swallowing it the alcohol in the beverage would be absorbed through the tissues in the mouth within 15 to 30 minutes.

Experiments have shown that alcohol can be absorbed into the blood stream directly from the stomach. The rate at which alcohol is absorbed from the stomach will depend upon whether the stomach is empty or not. Food or diluting liquids tend to slow down the rate of absorption of alcohol. Approximately 20 per cent of the alcohol consumed in a beverage will be absorbed from the stomach alone. The remaining 80 per cent is absorbed from the small intestine.

Ethanol is instantly soluble in water and is not very soluble in fat, and insoluble in bone. Following absorption from the stomach and small intestine, alcohol is transported very rapidly by the blood to all parts of the body.

Blood circulates at a rate of three to five quarts per minute. Therefore by the time absorption of alcohol from the stomach and gastrointestinal tract is finished the distribution of alcohol throughout the body is complete. At this time alcohol will be found in all of the body water and in approximately the same concentrations. Thus, the water in the brain would then have the same concentration of alcohol as the water in the liver or in the water of any other part of the body.

Water accounts for approximately two-thirds of the weight of an individual of average build. Thus, if such a person had a blood alcohol concentration of 0.15 per cent he would have a total body concentration of 0.10 per cent. Knowing the body weight, one could then calculate the amount of ethanol in his body. If the body weight were 150 pounds, it would contain three fluid ounces of ethyl alcohol. Three fluid ounces of alcohol are present in six ounces of 100 proof whiskey or six twelve ounces of 4 per cent beer. Under the provisions of most state laws it is presumed that an individual with this blood alcohol concentration is under the influence of alcohol and his driving ability is illegally impaired. At least 90 per cent of all absorbed alcohol is destroyed by the body. This destruction or metabolism largely takes place in the liver. A maximum of ten per cent of absorbed alcohol escapes from the body unchanged by excretion in urine, breath, or perspiration.

For all practical considerations, ethyl alcohol disappears from the body at a uniform rate which for most people amounts to one-third of an ounce per hour. Such a body loss of alcohol would correspond to a fall in blood concentration of 0.015 per cent per hour. While the rate of loss of ethyl alcohol from the body is fairly constant for most individuals, it may vary from one person to the next. For some people, the rate of disappearance from the blood might be as low as 0.010 per cent per hour and for some as high as 0.030 per cent per hour. Most people will be very near the average figure cited of 0.015 per cent per hour.

The destruction of alcohol is begun by enzymes in the liver. Ethyl alcohol is ultimately converted to carbon dioxide which escapes through the lungs and water. The rate of destruction of alcohol by the body can be influenced only by interfering with these and other similar chemical reactions. Unless the absorbed alcohol has produced coma, the intoxicated individual is respiring normally and thus has an adequate supply of oxygen. The breathing of oxygen or fresh air will therefore not alter the rate at which alcohol disappears from the body. Exercise will increase the body's metabolic rate but will not influence the activity of the enzymes responsible for ethanol's destruction. Therefore, exercise will not shorten the sobering up period. The peak blood concentration of ethanol may be lowered if carbohydrates are taken with or in an alcoholic beverage. The mechanism is unclear and the effect is not significant in either sobering or preventing intoxication. At the moment there is no drug, food or exercise that will significantly increase the rate of disappearance from the body.

On the other hand, there are effective ways of interfering with the metabolism of ethyl alcohol. The best known of these is the drug disulfiram, which blocks the destruction of acetaldehyde and allows it to accumulate in the body. The symptoms produced by this compound have been utilized in the treatment of alcoholics. Similarily, calcium carbimide and chlorpropamide have been recommended. The principal effect of alcoholic beverages on the body is due to the presence of the alcohol itself. The influence of the congeners which are responsible for the principle flavor and aroma characteristics of the beverages exert a minor physiologic effect, however important they may be to the psychological influence appreciated by the drinker.

As the concentration of ethyl alcohol increases in the blood, there is a reasonably predictable appearance of symptoms. An individual consuming from ½ to 1½ ounces of ethyl alcohol will acquire a blood concentration of from 0.03 to 0.07 per cent. This concentration will be accompanied by subjective effects on mood with euphoria. The principal effects will be mental as opposed to motor. Little significant effect will be observed on either blood pressure or heart rate although cutaneous vasodilatation will occur, producing a warm or tingling sensation in the skin. Gastric flow will increase, which explains the use of alcoholic beverages as an apertif or in conjunction with eating.

If 1½ to 3½ ounces of ethyl alcohol are consumed, blood concentrations between 0.05 and 0.15 per cent may be expected. As the concentration rises in the blood the effects previously described are intensified and motor impairment is initiated. The individual becomes much more responsive to his emotional en-

vironment, being happy, morose or belligerent. His decision making is more difficult and his motor responses are slowed. With increasing concentrations, motor and mental impairment increase.

Increased urine flow is produced by ethanol by interfering with the reabsorption of water from the kidney tubule. The moderate use of alcohol does not appear to deleteriously affect the healthy kidney.

The chronic abuse of alcohol is associated with a high incidence of fatty liver. This is certainly encouraged by the inadequate diet of many alcoholics. However, alcohol has a direct effect on the body's ability to utilize fat. In addition, alcohol lowers the body's resistance to many toxic agents. The mechanism for the liver cirrhosis associated with many alcoholics has not been unequivocally explained. An adequate protein intake minimizes the effect. The moderate use of alcohol by a well-nourished healthy person does not appear to seriously injure the liver.

Nausea and vomiting may appear with blood concentrations of 0.12 per cent and above. The usual picture of public intoxication is associated with blood concentrations of 0.25 per cent or above. Acute alcoholic deaths have occurred with blood concentrations as low as 0.35 per cent but usually are associated within the range of 0.50 to 0.60 per cent. With blood concentrations of 0.40 per cent, attained with the minimum consumption of eight to ten ounces of ethyl alcohol, the heart rate is slowed and cardiac arrest has occured with blood concentrations of 0.60 per cent. Death is usually produced by respitory arrest.

People who are drunk are nearly dead. If one considers 0.05 per cent alcohol in the blood to be a therapeutic range in the sense that many of the pleasurable effects of alcohol are experienced, with minimal toxic or unpleasant effects, then the fatal range differs by a factor of seven to twelve or more. This relative difference is less than that in the case of barbiturates. Were it not for the integration of alcoholic beverages in our society, alcohol would have to be classed as a dangerous drug observing all the regulations of prescription items.

Ethyl alcohol impairs all the faculties required for skilled tasks, such as driving an automobile. This impairment increases with the concentration of alcohol in the blood. Impairment can be measured in some people with blood concentrations as low as 0.03 per cent. As the concentration of ethyl alcohol increases in the blood, impairment is measurable in more and more people. When a concentration of 0.08 per cent is reached, all individuals are measurably impaired. Twenty-three states have enacted legislation making a blood concentration of 0.10 per cent presumptive evidence of being under the influence of alcohol for purposes of driving a car. Seven other states have created a new, lesser offense of driving while impaired if the suspect has a blood alcohol concentration of 0.10 per cent or more. One state has made 0.08 per cent alcohol in the blood presumptive evidence of driving under the influence of alcohol. Many states have lowered this limit to 0.10 per cent. Illinois has no implied consent law nor any statutory standard establishing a blood alcohol concentration as a presumptive amount for drunkenness.

In summary, ethyl alcohol is a poison by virtue of its depressant effect on the brain. It is rapidly absorbed and equilibrated with body water. Its effects are noted by the drinker subjectively before they can be measured objectively and are directly correlated with concentrations in blood or deep lung air. Alcohol is mostly destroyed in the body and at a reasonably uniform rate characteristic for the individual. By its depressive action, many body functions are impaired, especially clearness of intellect, acuity of judgment and muscular coordination. Because it induces pleasure it is popular. Because it is readily available it is potentially harmful. Chronic abuse is detrimental to the individual and society and is common enough for national concern. Socially acceptable drinking limits dangerously approximate a fatal dose. As mentioned above, were it not for several hundred years of cultural acceptance, alcohol would be a controlled substance with regulations comparable to the most dangerous drugs. Certainly, the fact that alcohol is involved in one half of our nation's annual automobile fatalities and injuries is reason enough for this assertion.

Chapter 7
LAW ENFORCEMENT

The Role of Law Enforcement

The first line of defense in dealing with drug abuse is an effective system of law enforcement. This "system" contemplates an interlocking, cooperative network of law enforcement agencies working together at the federal, state and local levels. It also envisions an international plan of collaboration with foreign countries such as Turkey, France and Mexico which contribute to the United States drug problem.

It is easy to criticize the effectiveness of law enforcement in dealing with the drug epidemic. Addiction and dependency continue to rise. Channels of illicit traffic remain open. Underground laboratories continue to proliferate. And organized crime continues to reap astronomical profits from the sale of narcotics. But closer analysis shows that placing the full blame for these conditions on law enforcement is unfair and largely unwarranted.

When compared with the other disciplines involved in the war against drug abuse, it is clear that law enforcement has done the most effective job in reducing the sheer quantum of misery produced by drugs. Moreover, of all the approaches to the problem, law enforcement has the best chance of meeting its commitments since it knows more about its clientele and has produced more operative theories than the other disciplines.

Rehabilitation and treatment have been generally unsuccessful although hopeful; research has been slow in coming and inadequate; preventive educational curricula are just being developed with no way of predicting the likelihood of success. The accomplishments in these areas have been, and for the present will continue to be, hopes for the future. For this reason it is essential that society accept these modalities for what they are—long range solutions to a problem. To intone the fact that new approaches in these areas hold out promises for future solution does nothing but state the obvious.

Law enforcement, without question, plays a primary role in checking the spread of drug abuse. If anything, it is necessary to hold the drug supply lines in check in order to enhance the probabilities for success of the long-range education, rehabilitation, and research programs; to give expectations the time and chance to become achievements. Law enforcement, in fact, offers the only practical approach to the immediate problem. With some drugs, it can "hold the line" and contain further spread. With others, it can virtually eliminate the problem.

The degree of effectiveness, of course, is dependent upon a wealth of factors — many of which are only ancillary to the law enforcement effort itself. Proper legislation, manpower, money, and adequate selection and training are vital to a productive system of law enforcement.

Objectives

It has often been stated that the objectives of drug law enforcement are to "reach the highest possible sources of drug supply and to seize the greatest possible quantity of illicit drugs before use." Implied in this statement is the underlying aim of destroying the illicit market and ultimately the entire menace of drug abuse. Notably absent is the objective of punishing the addict. The rationale for these stated objectives is based on simple arithmetic as applied to the drug distribution system. Heroin, for example, is imported in large quantities by the highest ranking underworld figures. The most common unit of measurement used by these drug dealers is the kilogram which is equal to 2.2 pounds. These bulk quantities, often 100 kilograms or more, are distributed to large-scale wholesalers in quantities of 10 kilograms each. The drug is then "cut" to perhaps 50 per cent strength and re-sold to 5-kilogram dealers. This process is continued until the drug is sold in "bag" quantities at 3 to 5 per cent strength to the ultimate user, the addict. In this hierarchy there may, therefore, be 5 or 6 distribution levels between the smuggler and the addict in a pyradimal structure where one smuggler can act as the source of supply for hundreds of addicts.

It is apparent, from the arrest and seizure statistics reported by the various Illinois law enforcement agencies, that the single most encumbering factor limiting the effectiveness of those agencies is a misdirection of efforts toward the lowest stratum of the drug distribution channel, i.e., the user himself. For instance, in 1970 the Illinois Bureau of Investigation reported a total of 519 drug-related arrests, including marihuana offenses. *Yet, a total of only 4½ ounces of heroin was seized.* A single 1 kilogram seizure would have netted approximately 35.2 ounces. In Chicago, the local police department made 13,875 drug-related arrests in 1970, and yet only 10.6 pounds of heroin were seized. This entire amount might have been equalled with the arrest of a single 5-kilogram dealer. As early as 1963 the President's Advisory Commission on Narcotic and Drug Abuse reported that "organized criminals in the United States are heavily involved in the illegal importation and distribution of narcotic and dangerous drugs, but they have to a disturbing extent shielded themselves from arrest and prosecution." This continues to be true in Illinois today.

More than 40 percent of the cases generated nationally by the Bureau of Narcotics and Dangerous Drugs, according to that federal agency, involve addicts who are also peddlers. In theory, the highest "quality" arrests are those of non-addict sellers. The Presidential Commission on Law Enforcement recently observed that the percentage of addict-sellers prosecuted by the states is even higher. Although figures are unavailable, state law enforcement authorities have told the Commission that arrest rates of addict-sellers in Illinois are comparable to the disproportionately high ratios encountered in other states.

The user being in the most populous class of violators and often the most easily recognizable, is at once the easiest drug offender to arrest, but also the least significant in terms of impact on the flow of traffic in illegal drugs. It would require the arrest of dozens of ultimate users to equal the impact of the arrest of one dealer in the next higher stratum. Unfortunately, for every addict who is arrested there is another, eager to make a connection, to take his place. The flow of traffic never subsides and the drug problem continues to grow. One notable result of this failure to bring pressure upon the higher echelons of drug traffickers is the fact that the retail price of heroin has remained constant over the past 10 years. In fact, in terms of real money value after allowances for inflation, the price has actually decreased during that time. This economic reality is an indication that 1) the supply of illegal heroin continues to grow to meet the demands of an increasing addict population; and 2) there has not been an appreciable increase in risk imposed upon the suppliers by law enforcement.

State and local authorities cannot be expected to concentrate primarily on the very highest-

ranking criminals in the drug traffic chain. That is more properly the function of federal agencies who are better equipped to investigate the international and interstate movement of the drugs. However, with state and local efforts concentrated on the very lowest stratum, an enforcement vacuum is created with respect to the intervening levels. Illinois is not alone in this mis-direction of efforts: in New York City one municipal judge estimated that 99 per cent of those persons charged with illegal possession and sale in that city over a five-year period were themselves drug users. It is the conclusion of the Commission that it is the responsibility of police administrators to shift the aim of their efforts to higher targets within the drug chain. A redirection of this kind will result in smaller numbers of arrests per year, but it will have a much greater net effect on the drug crisis. In addition, seizure figures should increase to where there is a significant diminution of the supply of drugs available to addicts.

There is also a need to redirect the efforts of police agencies to the types of drugs which warrant the most urgent attention. There seems to have been in the past a disproportionate amount of attention placed on the arrest of marihuana users and the seizure of marihuana and hashish. These drugs are still dangerous and illegal, but the changes in the laws relating to marihuana reflect the consensus of the legislature that marihuana should not be classed with heroin and other highly dangerous substances. Therefore, police administrators should place their enforcement emphasis on drugs which are of the greatest social concern as reflected by their treatment in the statutes.

The Commission encourages the law enforcement community to take a more active part in drug education, especially among the very young (i.e., below the fifth grade level). It has been our experience that the police officer in uniform generally enjoys a unique advantage in this area, in that he presents an imposing, trustworthy figure whom school children sincerely respect. He can be exceptionally influential if he is given the opportunity to present a well-conceived, thoroughly honest anti-drug message to these children. We have witnessed the highly successful presentation of Officer Herbert Lee of the San Francisco Police Department and would recommend that similar programs be instituted in Illinois through the various state and local police departments in cooperation with their respective boards of education. In addition, there is a need to educate the public generally on drug law enforcement activities so that citizens may better judge the effectiveness of agencies on the basis of net impact on the total drug problem rather than on the simple criterion of arrest volume.

Mobilization of Efforts

Just one decade ago law enforcement efforts against drug abuse were a mere shadow of the leviathan endeavors witnessed today. At the local level most metropolitan law enforcement agencies have increased their investigative commitments to illicit drug suppression. Some sheriff's departments are now engaging in more vigorous anti-drug enforcement programs. At the state level groups such as the Illinois Bureau of Investigation and other police agencies with state-wide jurisdictions have promised to redouble their future enforcement efforts.

On the national scene the Federal Bureau of Narcotics and Dangerous Drugs (BNDD) has been able to mount a truly impressive attack on the drug problem. The opening of overseas offices by the BNDD and cooperative agreements with foreign countries have done much to check illicit drugs at their sources. In addition to agreements with Turkey and France (See Chapter 5,) recent accordance with Mexico give promise of increased cooperation in the fight against illicit drug traffic crossing our southern border. New agreements have been reached with Mexican authorities as a part of a continuing program known as "Operation Cooperation." The program includes the exchange of surveillance and enforcement techniques, equipment, technical assistance, training, exploration of mutally beneficial legislation and a series of programs designed to detect and eradicate Mexican opium poppy and marihuana fields.

Major actions against large scale distributors have also become common activities of the BNDD. Operation Eagle, a lengthy BNDD investigation which was closed out in June, 1970, resulted in the confiscation of thousands of dollars worth of marihuana and other drugs from persons attempting to cross the Mexican-American border. The investigation also disrupted a major cocaine smuggling group and concluded with the arrest of more than 160 persons in ten large cities.

A second highly successful BNDD investigation was Operation Flanker. This was the code name for an intensive six-month investigation involving more than 200 agents. On February 24, 1971, the operation climaxed the simultaneous arrests of 54 major organized crime

figures in New York City, Hartford, Connecticut, Chicago and New Orleans. Eighty-eight other defendants had been arrested previously in Philadelphia, Detroit and Baltimore. The operation removed from the illicit market 71.25 pounds of heroin, 49.2 pounds of cocaine, 256 pounds of marihuana, and 7,263 dosage units of other dangerous drugs. The cache represented a total street value of some $12.8 million.

The United States, through the BNDD, has also signed a bilateral pact with France whereby the Surete Nationale authorities have agreed to augment their staff and efforts to strike at the heroin sources of supply in their country. It is interesting to note that whereas there were only 7 federal French law enforcement authorities engaged exclusively in the suppression of the illicit traffic in that country there are now well over 200 such officers.

Arrests and Seizures Data

1. *Introduction.* As intimated earlier, law enforcement is but a single cog in the machinery that will be required to stop our rampaging drug problem. It is, however, singularly vital for short term results. Law enforcement's function as the first line of defense against drug abuse makes it imperative that steps be taken to measure its efficiency and calculate the success of its operations. Without this type of measurement law enforcement could become a directionless force with no means by which to maximize the effects of its efforts. Unfortunately, the state of police reporting and performance analysis today offers relatively inadequate data on which to base this measurement. Especially is this true in the area of drug abuse statistics due to our volatile, dynamic social environment where there are many yet unexplained undercurrents which contribute to the total drug abuse picture. The only factual, objective data which can be used for statistical purposes are arrest data and these, though valuable, leave much to be desired in terms of reliability and accuracy.

Arrest data are useful to the extent that they act as an activity index for law enforcement agencies. They help to focus attention on those areas where there does not seem to be sufficient police activity to deal with prevailing conditions. In addition, arrest data provide a demographic sampling of the population of drug offenders which might otherwise be unavailable. They indicate arrests according to age, sex, race, and geographic area.

The volume of drug traffic in Chicago is evidenced by this portion of material seized in one recent raid.

Arrest data are somewhat incomplete or inappropriate for statistical surveys of the drug problem for a number of reasons. One obvious difficulty is that not all drug abusers are arrested, so that projections of the total problem must be based on a subjective factor correlating the number of persons arrested with the total number of drug violators. This factor, though conscientiously derived, is but an estimate and may not be reliable. As a consequence, the estimates of the total number of narcotic addicts in the United States vary by as much as 100,000. In fact, there are vast differences in estimates even for individual cities. It seems improbable that an effective solution to the drug problem can be evolved without an accurate estimate of the magnitude of the problem.

Secondly, arrest data are not uniform throughout the state. Often these data are reported without accounting for recidivists, i.e., persons who are arrested more than once for drug related crimes. Other data omit certain demographic information which would be helpful to drug abuse prevention and treatment planners. For this reason the Commission has suggested that a Uniform Drug Arrest Form be prepared for use by all law enforcement agencies throughout the state, which would be forwarded to a central collection point for analysis. By this method, the application of computers could bring vital information to responsible agencies on a day to day basis and be invaluable for purposes of long-range planning.

In this regard the Commission urges the law enforcement community to expand its interest and concern in gathering sociological data in conjunction with arrest data, and to cooperate more fully with the behavioral science disciplines so that they may facilitate their work through the use of complete and accurate research data. It has been brought to our attention that persons and organizations engaged in research often experience great difficulty in obtaining drug arrest statistics from law enforcement units. This lack of coordination can only be harmful to long-range hopes for successful treatment and prevention techniques.

A third factor is that there is often a lack of follow-up information to accompany the arrest data. Arrests do not necessarily imply violations of the law, and data concerning the final dispositions of arrestees would be vital to the accuracy of statistical analyses.

The Commission learned, for example, that in Cook County the State's Attorney's office maintains no continuing, complete accounting of the cases which are brought through their office. The explanation was given that the case load of the Narcotics Division is so large (300-500 cases per day) that detailed record-keeping is prohibitively expensive in terms of personnel and other resources; and that by not keeping continuing records the State's Attorney's office obviates the allegedly often-claimed charge that multitudinous convictions are the sole aim of prosecuting agencies.

Notwithstanding deficiencies in uniformity and technical accuracy, arrest data are valuable for discerning trends in criminal activity. Assuming that the level of law enforcement capability and activity remains constant, comparisons can be made between years or geographic territories to indicate whether crime rates are increasing or decreasing. As will be demonstrated below, the statistics provided by the various law enforcement agencies in Illinois indicate a drug abuse problem of gross proportions.

2. *Illinois Department of Law Enforcement.* Drug arrest statistics are reported by all law enforcement agencies which operate within the state. These include federal, state, and local units. On the state level, the organization primarily responsible for drug abuse detection and investigation is the Department of Law Enforcement. This department, created at the request of Governor Ogilvie on January 1, 1970, established the Illinois Bureau of Investigation (IBI) as a statewide investigative unit. The tasks of this group is to curb organized crime, and to slow the mounting traffic in narcotics and dangerous drugs throughout Illinois. The IBI is empowered with statewide police authority which enables it to investigate criminal activities at the request of and in cooperation with local police departments. It does not, however, obtain drug-related arrest data from these local and county units. In 1970, the Department of Law Enforcement reported the following drug-related arrests:

Sale of Narcotic Drugs	240
Possession of Narcotic Drugs	205
Sale of Dangerous Drugs	32
Possession of Dangerous Drugs	16
Fraud and Deceit of Drugs	6
Forgery of Drugs	2
Possession of Hypodermic Needles and Syringes	6
Narcotic Violation (General)	9
Unlawful Shipment of Marihuana	2
Parole Violation of Narcotic Charge	1
Total Drug Arrests	519

In 1970 marihuana was legally considered to be a narcotic drug. Consequently, the total of 519 arrests would include an unknown number of marihuana arrests. We were informed that in 1969 a total of 406 persons were arrested by the department for violations of the narcotic laws and 104 were arrested for violations of the dangerous drug laws. Thus, the total arrests for 1969 was 510. A more detailed breakdown was not available.

By products of drug arrests are the seizures of illegal drugs which are sold or possessed in violation of the law. The IBI has compiled its seizure figures on a fiscal year basis; consequently, there is not a direct correlation between the arrest data and the seizure figures.

Between July 1, 1968 and June 30, 1969, agents of the IBI seized the following drugs:

Marihuana	131,254 grams (293 lbs.)
Heroin	52.32 grams (2 ozs.)
LSD	470 capsules and tablets

In the following fiscal year ending June 30, 1970, the IBI seized the following drugs:

Marihuana	687,303 grams (1533.75 lbs.)
Heroin	119.43 grams (4½ ozs.)
LSD	17,492 capsules and tablets

Between July 1, 1970 and December 31, 1970, the IBI seized the following drugs:

Marihuana	10,926.54 grams (24 lbs.)
Heroin	302 grams (10.7 ozs.)
LSD and Mescaline	3,120 capsules and tablets
Amphetamines and Barbiturates	263 capsules and tablets

In addition to these substances, IBI agents also seized unknown quantities of other drugs including opium, mescaline, codeine, and methadone. No seizure data were available for years preceding the fiscal year ending June 30, 1969.

3. *U. S. Bureau of Narcotics and Dangerous Drugs.* The Chicago Regional Office of the Bureau of Narcotics and Dangerous Drugs reported the following data. In 1970 that office made 293 arrests for violations of the federal drug laws. The following seizures of illegal drugs resulted:

Marihuana	265,973 grams (593 lbs.)
Hashish	2,142.9 grams (4.75 lbs.)
Heroin	8,483 grams (19 lbs.)
Cocaine	8,626 grams (19¼ lbs.)
Hallucinogens	116,884 dosage units
Depressants	1,405 dosage units
Stimulants	28,338 dosage units

For the quarter January-March, 1971, that office made 88 arrests and the following siezures:

Marihuana	715,740 grams (1,597.6 lbs.)
Hashish	None
Heroin	5,436 grams (12 lbs.)
Cocaine	2,565 grams (5½ lbs.)
Hallucinogens	7,291 dosage units
Depressants	15 dosage units
Stimulants	2,038 dosage units

For a comparison with seizures throughout the United States, the Bureau of Narcotics and Dangerous Drugs provides the following figures:

	1969	*1970*
Marihuana	8,925 pounds	17,402 pounds
Heroin	140 "	427 "
Cocaine	73 "	197 "
Hallucinogens	24,580,000 units	7,128,000 units
Depressants	748,050 "	2,339,000 "
Stimulants	3,832,000 "	7,196,000 "

4. *U. S. Bureau of Customs.* The arrest and seizure statistics released by the U.S. Bureau of Customs for the Chicago area are even more startling. In the fiscal year ending June 30, 1971, agents seized the following illegal drugs in 184 separate arrests:

Marihuana	1,400,755 grams (3,126.6 lbs.)
Hashish	31,991 grams (71.4 lbs.)
Opium	12 grams (185 grains or .4 oz.)
Heroin	7 grams (118 grains or ¼ oz.)
Dangerous Drugs:	
Dexedrine	30.5 grain units (1 oz.)
Synthetic narcotics	383.5 grain units (9/10 oz.)
Methylene dioxy amphetamine	225 grain units (½ oz.)

For comparison, in the fiscal year ending June 30, 1970, that same office seized the following illegal drugs:

Marihuana	114,258 grams (255 lbs.)
Hashish	20,460 grams (48 lbs.)
Opium	16 grams (½ oz.)

Figures for arrests and amounts of dangerous drugs seized during that year are not available.

5. *Chicago Police Department.* As could be anticipated the local police forces in highly urbanized areas have the greatest volume of narcotic arrest activity. The Chicago Police Department in 1970 made 13,875 arrests for drug related crimes, as compared to 9,133 the previous year. Of these arrests, 60 per cent were for the sale and possession of marihuana,

the remaining for "hard" drug offenses. In 1970 the department seized the following drugs:

Marihuana	739,330 grams (1,650 lbs.)
Heroin	4,781 grams (10.6 lbs.)
Amphetamines	23,229 grams (51¼ lbs.)
Barbiturates	89,687 grams (200 lbs.)

6. *Total Illinois Seizures in 1970.* On the basis of figures provided by federal, state and Chicago police departments, we calculated that the following seizures were made in Illinois during 1970. Although we do not have figures for seizures made by other local police departments, and by the 102 sheriff police departments, we do not believe they would appreciably alter these amounts.

Drugs	*I.B.I.*	*Chicago P.D.*	*BNDD*	*U.S. Customs*	*Totals*
Marihuana	1,557.75 lbs.	1,650 lbs.	593 lbs.	3,126.6 lbs.	6,927.35 lbs.
Hashish			4.75 lbs.	71.4 lbs.	76.15 lbs.
Heroin	15 ozs.	10.6 lbs.	19 lbs.	¼ oz.	30.2 lbs.
Cocaine			19.25 lbs.		19.25 lbs.
Opium				.4 oz.	.4 oz.
*Hallucinogens			116,884 units		116,884 units
Depressants		89,687 units	1,405 units		91,092 units
Stimulants		23,229 units	28,335 units	639 units	57,203 units

* Each unit is approximately 1 grain — there are 437.5grains to the ounce.

Cooperation Among Police Units

The data presented above indicate the tremendous magnitude of the illegal drug trade today in the United States and in Illinois. Comparison figures show that both arrests and drug seizures are on the rise. The size of the problem and the known complexity of the drug traffic channels make it clear that the only hope for significant success in combating the drug menace lies in total cooperation and coordination among law enforcement units. The problem is simply too overbearing to be handled by sporadic, uncoordinated or fragmented enforcement efforts. The resources and particular advantages of local, state and federal agencies must be pooled and employed in accordance with comprehensive plans to be effective against the underworld complex which controls the flow of traffic in illegal drugs. The success of highly coordinated efforts has been demonstrated recently in raids such as Operation Flanker, mentioned above, which took some $12.8 million from the hands of organized criminals.

The Federal Bureau of Narcotics and Dangerous Drugs, recognizing that smaller police departments and other local units are not properly equipped to detect, investigate, and apprehend drug traffickers, has sponsored and advocated the development of "Metropolitan Enforcement Groups" (MEG's) which pool the efforts of closely situated police units.

As of March of 1971 the BNDD announced that 18 such MEG programs were already operational in the United States and 28 were in the development state. Through the efforts of the BNDD many of these MEG programs have received financial assistance from the United States Department of Justice's Law Enforcement Assistance Administration (LEAA) to obtain necessary resources and support. In fiscal 1970, LEAA appropriated $350,000 from its discretionary funds for the initiation of MEG programs and encouraged state planning agencies to utilize their block action grants to support this concept.

Illinois did not avail itself of this opportunity to establish a MEG program through LEAA financing until July of 1971. At that time a $200,000 LEAA grant was given to 19 North and Northwest Chicago area suburban communities that formed a MEG organization in Illinois. Clarence I. Emrikson, Chief of Police of Niles Township was elected as temporary MEG director by the following police department participants: Arlington Heights, Barrington, Des Plaines, Highland Park, Hoffman Estates, Lake Forest, Lincolnwood, Morton Grove, Mount Prospect, Niles, Northbrook, Northfield, Palatine, Park Ridge, Rosemont, Skokie, Waukegan, Wheeling and Wilmette.

The initial grant will be used to conduct a concerted drug enforcement training school starting in September of 1971. A total of 19

State police detectives inventory a seizure of 140 pounds of processed marihuana. It was retrieved at the scene of a fatal vehicle accident.

officers were selected to matriculate in a ten-week training course with one representative from each of the participant police departments. Training will be conducted by the BNDD, representatives of the Narcotics Section of the Illinois Bureau of Investigation, and local experts outside the field of law enforcement. Upon completion of this initial training course the 19 officers will form the nucleus of an intelligence unit that will serve all member departments of MEG. Their declared intention is "not to arrest a bunch of high school students who are experimenting with drugs but to go after the source, the supplier, the wholesaler." Eventually, through anticipated additional LEAA award applications, MEG expects to train a total of 800 officers. Furthermore, MEG director Emrikson said he hoped additional municipalities will come into the group.

We commend this pioneering cooperative effort by suburban police departments in nothern Illinois and trust that its success will energize small police departments within other metropolitan areas of Illinois, where acute drug abuse problems exist, to form additional MEG organizations with federal funding.

One such potential MEG operation is currently under consideration by Du Page County Sheriff Wayne S. Shimp. About one year ago he started a collective law enforcement effort with the suburban police departments of that county. Thus far it has proceeded without the use of outside financing. However, we have been told that it is now preparing an application for LEAA financing and we are optimistic that it will be successful.

Another collective effort has reaped success in Mc Henry County. In June of 1971 the Mc Henry County Sheriff, Arthur Tyrrell, supervised an operation which netted the arrest of 35 persons on drug charges and indictments on 51. The operation had been in progress for five months and had involved all the police departments in the county. Undercover men from the Federal Bureau of Narcotics and Dangerous Drugs were used to infiltrate the illegal drug market and make purchases of drugs. The arrests were made swiftly and efficiently when sufficient evidence had been gathered.

Sheriff Tyrrell has accomplished much in his county to stem the abuse of drugs. He has made particular use of "rap sessions" where he and young people can engage in free and open discussion of contemporary problems.

Citizen Support

The coordinated effort of law enforcement described in the previous section is incomplete without the commitment and cooperation of private citizens with law enforcement agencies. Citizen support is more vital in relation to the enforcement of the narcotic and drug laws than in any other area of law enforcement. The reasons are obvious: the private citizen, if he is able to recognize the symptoms, is in a better position to discern drug problems when they begin; and, since drug violations are virtually always repetitive, the private citizen can be of inestimable value by reporting suspicious behavior by persons in his community. The widespread use of drugs today, plus the unwillingness of apprehended offenders to disclose the identities of their accomplices and suppliers, make this sort of intra-community surveillance necessary.

Citizen support also has many other facets, each contributing to the total effort against drug abuse. The most rudimentary is to refrain from interfering in police operations. For instance, it requires no comprehensive understanding of police operations to appreciate the tremendous blow to law enforcement efforts caused by the Los Angeles *Free Press*, an underground newspaper, which published the identities of local narcotic agents and the identifying characteristics of their vehicles.

On the positive side, however, there are encouraging developments here in our own state. In Deerfield, Illinois, concerned citizens have bonded together within a corporate structure to fight drug pushers. Their organization, called A.I.D.S. (Anti-Illicit Drugs in Schools) operates a 24-hour telephone service where community residents may anonymously report known pusher activities. Substantial rewards are offered to informers whose information leads to the arrest and conviction of a drug pusher.

Mr. Roy Kissling, Chief Organizer of A.I.D.S., explains that information received by the telephone operator is relayed to the local police, thereby insuring the anonymity of the informer. Callers are identified by number for purposes of rewards. The Deerfield organization is a chapter of a similar program begun last January in Joliet, Illinois. Funding is through donations by service organizations and the Rotary Club.

Joliet statistics show that since the program began last January, information has been received on 291 persons, 89 of whom have been investigated and 41 of whom were arrested. As of July 27, 1971, two of these persons have been convicted and many cases are pending. Joliet officials said that from the 41 individuals arrested police have confiscated marihuana valued at $15,500, heroin valued at $5,000, cocaine valued at $605 and amphetamines and barbiturates valued at $2,500.

Deerfield is the fifth chapter of the A.I.D.S. program, with other chapters in LaSalle and Putnam Counties. Joliet officials reported that seven other inquiries have been made.

The Commission applauds the efforts of these organizations and the concerned citizens who comprise their membership. Law enforcement officers can be greatly assisted through the help of private citizens, as exemplified by the A.I.D.S. groups. We encourage all citizens to participate in the struggle, either through organizations or individually, because their cooperation, above anything else, will determine the success or failure of the fight against drug abuse.

Judicial Problems

Police operations are but the beginning of bringing justice upon drug offenders. After the arrest there must be vigorous prosecution to ascertain guilt and, thereafter, an informed and enlightened judiciary to order appropriate dispositions of those convicted. These functions play a large role in the fight against drug abuse, for without effective prosecution and intelligent sentencing, the most successful police operations will be meaningless.

It is the responsibility of the prosecutor to represent society in lawsuits against persons who have allegedly committed wrongs against society, or crimes. Crimes are generally defined by statutes, and problems arise when the written law, in the opinion of prosecutors, juries, and judges, no longer accurately represents the consensus of the public as a proper definition of "crime". This had been the case prior to the passage of the Illinois Controlled Substances Act and the Cannabis Control Act by the 77th General Assembly in 1971. As discussed in Chapter 1 of this Report, the previous law had demanded punishments for drug offenses which were not in harmony with current theories and opinions on drug abuse in general. Marihuana was inaccurately considered a narcotic drug and was controlled by laws which provided penalties nearly as harsh as those for offenses involving heroin. LSD and the other mind-shattering hallucinogenic drugs were, however, defined as "Dangerous Drugs" and rarely were the subjects of anything more serious than misdemeanors. This untenable situation faced prosecutors, judges and juries with the dilemma of being obligated to enforce laws which seemingly were unwise, unpopular, and likely to be changed soon by the Legislature. Consequently, the mandate of the written law, especially relating to marihuana, was often circumvented by reducing charges, plea bargaining, acquittals in the face of overwhelming evidence, or dismissal of the cases entirely. The harsh marihuana law ironicaly became nearly ineffectual due to its inability to be enforced. It is anticipated that the newly enacted drug law in Illinois will meet with popular approval, afford more discretion and flexibility to judges and prosecutors, and ultimately be more effective in stemming the drug abuse problem. A full discussion of this new drug legislation can be found in Chapter 1 of this Report.

Other problems continue to be raised by the drug abuse crisis. Earlier this year it was reported that hundreds of indigent Narcotics Court defendants in Chicago are being jailed for days, even weeks, awaiting the results of routine drug analyses which can ordinarily be performed in a matter of minutes. Court officials explained that this delay is due to the shortage of police laboratory personnel and the extremely large case load of the court. Persons who have been arrested and cannot afford bail are held in custody until the laboratory tests

are complete. If the tests prove negative, the charges are most often dismissed for lack of evidence that a crime has been committed. Judge Fred G. Suria explained that the likelihood of negative test results has increased because of the heavy flow of fake narcotics and other drugs on the street. To counter the possibility that innocent men may be unjustly deprived of their freedom, Judge Suria has instituted procedures which either expedite the testing process or allow the defendant to remain free while the results are pending. The net result has been a decrease in the average waiting time from eight weeks earlier this year to a recent average of three weeks. It was learned that there has been a 14 per cent increase in the volume of police laboratory tests so far this year.

A recent seizure of illicit drugs is carefully weighed and tested by state police officials.

Conclusion

Effective law enforcement is vitally important in the collective effort to stop drug abuse. It acts as a first line of defense as the other disciplines are yet developing the knowledge and techniques which optimistically will be most valuable in the long run. Obviously, the law enforcement effort is not perfect, as witnessed by the rapidly increasing incidence of drug abuse among our citizens, and it is most unfortunate that the means for determining the actual effectiveness of law enforcement are unavailable due to a general lack of coordination among agencies and a lack of standardized, complete, and accurate arrest and disposition data.

There appears to be a misdirection of enforcement efforts within Illinois which concentrates primarily on the lowest level of the drug traffic, the user himself. The thrust of police efforts would be better placed toward the higher echelons of the supply chain because the removal of a higher ranking dealer has many times the impact of the arrest of an addict. This redirection should also shift emphasis from marihuana to the drugs which are of the greatest social concern.

The most disconcerting problems facing law enforcement today are related to limited manpower, training, finances, and an atmosphere of apathy, indifference, and ignorance on the part of citizens generally. A large number of parents do not know the symptoms of drug abuse and are unable to detect or acknowledge that their own children might be involved. In addition, what appears to be ineffective court action after apprehension tends to discourage and demoralize law enforcement officers who may feel that the efforts required to bring about an arrest are not justified by the results after prosecution and trial.

This seemingly ineffective court action is the result of previous drug laws in Illinois which called for severe mandatory penalties for most offenses, leading prosecutors, judges and juries to take actions to circumvent the law rather than be forced to impose inappropriately harsh sentences.

In Illinois, there has been enacted a totally new system of legal controls against drug abuse, designed to strike hardest against the large-scale pushers of illegal drugs and allow the courts more discretion in sentencing. The Commission is optimistic that these new laws will enable law enforcement to become more effective in its battle against drug abuse.

The Commission commends the initiative of the Cook County State's Attorney's office in this

regard for their recently developed program which offers guidance to young first offenders of the drug laws. Through this new program young people are granted a continuance before trial, during which time they must attend a series of five group guidance and counselling sessions which are held on Saturday mornings at the Chicago Civic Center. If the arrestee attends all five sessions and is not arrested for drug violations for the next two succeeding months, the charges against him are dropped. Admission to the program is entirely at the discretion of the State's Attorney. Thus far there have been nearly 600 persons who have attended the program, and only three have been arrested during the two month period. The Commission views this program as exemplary of the concern which should be demonstrated by all law enforcement agencies for the most rational, socially beneficial treatment of first time drug offenders. It displays the application of sociological principles to the traditional functions of law enforcement.

The Commission also commends and encourages the participation of private citizens in the struggle against drug pushers. The A.I.D.S. programs exemplify the community commitment which will assist law enforcement authorities to accomplish their goals.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Chapter 8
DRUG EDUCATION

Introduction

At a very early point in the Commission's research into the drug crisis in Illinois it was apparent that no remedies could be effective without the eventual establishment of a broad, coordinated system of drug education at a statewide level. School-age children should have an accurate and adequate knowledge of modern medicine, illicit drugs, and other chemicals that have a potential for abuse.

The widespread and unprecedented use of drugs for non-medical purposes has led this Commission to conclude that drug education should be instituted as an essential separate component of elementary and secondary school instruction. The members of the Commission are agreed that education about drugs should be a part of the regular health education curriculum in all Illinois grade schools and high schools. Education about drugs which is carefully planned and effectively presented can become a major force in preventing drug abuse, in upgrading the quality of health instruction, and in improving the life and health of today's youth.

General Considerations

The use and abuse of drugs are now issues of major concern and are consequently the target of widespread publicity. Dramatic accounts of the abuse of some drugs have overshadowed the extensive benefits of most drugs. Indeed, the extent of drug use, the sensational stories of abuse, and reports of catastrophic episodes concerning drug abusers have led to extensive misinformation and misconceptions about drugs.

In view of this situation, it is imperative that accurate scientific information be made available to those who are charged with the education of youth. Educators need a clear understanding of the facts in order to make clear, unbiased presentations to their students.

Drug education should start in the early school years and continue throughout the school experience. Effective education in the construc-

tive use of drugs can be assured only by conscientious planning to integrate the subject with the total health education program. In this way, the pupil can receive throughout his entire school life, the necessary comprehensive instruction about the relation of drugs to total health.

It is strongly urged that a positive, rational approach be used in drafting any drug education curriculum. Throughout our inquiry we were continuously admonished by authorities in pharmacology, medicine, education and law enforcement that the "scare" technique is an ineffective and outmoded method of teaching about drugs. On several occasions the Commission was told that much of the drug experimentation which has become rife among our youth is based in part on their loss of confidence in the credibility of teachers and others from the older generation. Stern, exaggerated warnings about the evils of marihuana were proven to be myths by the thousands of young persons who have used the substance. Unfortunately, many youths then made the false conclusion that warnings concerning other drugs were also fabrications.

Another major consideration is the currency and accuracy of the data being presented. The use of dated terminology frequently serves only to underscore the age difference between student and teacher. Movies and other visual aides depicting fashions and other items such as automobiles from another era are poor teaching devices. In today's world, information which is old is immediately suspect among young persons.

The Commission is of the opinion that representatives from many disciplines involved in the drug problem can make effective presentations to school children both at the primary and secondary levels. Only in this way can the student gain an adequate perspective of the many aspects involved in the crisis.

We suggest that law enforcement personnel with relevant experience can be particularly valuable in presenting a balanced approach to drug education. According to John Ingersoll, Director of the Federal Bureau of Narcotics and Dangerous Drugs, "The final solution to our drug abuse problem lies in education, a change of attitudes. To be effective, this effort must tap every source of our power — the family, the church, the school, the politician, the scientist, yes, especially the policeman." We agree with Director Ingersoll that there is a deep and growing reservoir of talent and expertise in the wellspring of law enforcement.

In San Francisco the Commission was fortunate to meet Inspector Herbert Lee of the San Francisco Police Department. Inspector Lee is in charge of drug education for the department. He demonstrated to us that in this era of cynicism it is still possible for police officers to be heard and understood as sincere proponents of drug abuse prevention among our youth. (See Chapter 12 for a full discussion of Inspector Lee and the San Francisco Program).

The Need for Drug Education

Apart from the obvious benefits in having an informed populace, there is a more urgent reason for providing effective drug education programs in our state's schools. It is a simple fact that cogent information about the hazards of drug abuse is a necessary adjunct to effective law enforcement.

With certain qualifications, the law of supply and demand operates in the illegal drug market in the same manner that it does in any other market place. It has been shown in many cases that education works to reduce the demand for certain drugs.

It is evident that drug laws per se are not total deterrents to drug abuse. Law enforcement, the judiciary, and correctional institutions are strained to the utmost of their capacities, and still it is estimated that more than two million American youth have tried or are smoking marihuana. It is improper to blame this epidemic on law enforcement. Laws can never prevail completely against a tide of new attitudes and a network of informal distribution and exchange. If society intends to reverse certain patterns of behavior which it finds undesireable, it must formulate a program which includes the means to change interests and attitudes.

A graphic example of the effect of education on demand can be seen in the case of LSD. Law enforcement authorities have recently witnessed a distinct lessening of interest in LSD among college students and other "hip" types who used the drug in recent years. This is especially true on the West Coast. Authorities attribute this decline to three factors.

One reason was the visible evidence of bad trips users saw among their own acquaintances, or experienced themselves. Another was the denunciation of drugs by a few demigods of the psychedelic set. And last, but probably most influential, was the spread of knowledge of possible permanent psychosis and damage to unborn children.

Many educators believe that similar successes can be enjoyed with other drug varieties—even heroin. In this regard it is important to make two initial observations about the ecology of heroin addiction.

First, most active addicts in this country reside in large cities, and disproportionate numbers of them are young, minority group residents of slums. Second, this has been a comparatively stable group in terms of number and composition, not increasing at nearly the rate of abusers of other drugs such as marihuana.

Although education on the hazards of narcotics has been in existence for many years there is evidence that ghetto children may not be receiving this information. Isidor Chein's study, *The Road to H,* presented strong evidence that the slum children of New York who are the prime subjects for addiction actually do not know the facts. Only 17 per cent of a group of 133 young users in the New York slums reported learning anything cautionary about drugs before their first experimentation with it.

If we have faith in education and our own ingenuity to discover workable teaching methods, it is not unreasonable to conclude that even heroin addition can be reduced through the dissemination of accurate information.

The Goals of Drug Education

Most states, including Illinois have laws requiring instruction in drug education. Until recently, however, few good curricula were in use in this country. In recent years several groups have conducted research in drug education programs. Moreover, several agencies now offer suggested model programs for establishing drug abuse prevention and education programs. Included is the Bureau of Narcotics and Dangerous Drugs' Divisions of Education and Drug Science and the National Institute of Mental Health.

Still, there is a lack of information on drugs, a lack of effective methods of teaching about them, and a tremendous deficiency in the training of teachers.

The problem of drug education is both long and short range. In the short range, crash programs to educate pre-teens and teens now in school have met with limited success because of the already developed attitudes of these youths. The example of adults, using and abusing legal and prescribed drugs such as tobacco, alcohol, tranquilizers, and commercially sold remedies of many kinds, has made it difficult to achieve credibility with the teen and pre-teen groups.

In the long range, children in kindergarten through the elementary grades need information and experiences that develop attitudes and values which can influence them to reject the easy, counterfeit routes to a satisfying way of living.

Possible Solutions

Our society must become more aware of the problems associated with drug education and must work toward solutions. What is needed, in general, is more information, more concern for educative programs about drugs, more study and research about the effects of drugs, but most of all, the development of proper attitudes in all our citizens.

In the short run, this can be done through the use of mass media, through making parents aware of the problem, and through programming schools to provide information about the effects and social and personal consequences of drug abuse.

In the long run, our society must become aware of the problem of chemical dependence of all kinds. Drug abuse is only another aspect of the effects of chemicals in our lives. Chemicals process our food and water, but they also contaminate it along with our air, water and soil. We have not yet learned to cope with the problems of chemical processing when our very existence depends upon it. The old dilemma of whether or not to tell children about drugs no longer exists. The problem has become what to tell them and how to tell them. In this regard, however, extreme caution must be exercised. There is always the danger that education might make drug taking too exciting and therefore attractive. There is the related danger that education may serve only to instruct impressionable young persons on the mechanics of drug abuse. An example of both of these hazards can be seen in the objection of various law enforcement agencies to motion pictures such as "The Man With The Golden Arm." At the time of its production during the 1950's heroin addiction was a comparatively unknown phenomenon to most American young persons. The danger inherent in showing the preparation and injection, it was argued, could possibly serve to arouse an impressionable youth's curiosity and cause him to experiment with heroin.

We are, however, now in a situation where we have been *finessed* by the mass media, our own youth, and the gurus of the drug revolution. Moreover, we have inherited a credibility gap — a gap produced by years of hard sell by well-meaning doctors, teachers and government officials at all levels. We have no

choice now but to tailor our programs to existing conditions. Unfortunately, we must accomplish this with imperfect knowledge on how to do a truly effective job.

Attitudes and values must be developed toward drugs which characterize them as having potential for great good when properly used and great harm when improperly used. Effective educational programs must let children from the earliest years learn to understand that drugs are not a substitute for, nor an escape route from, problems which seem unfortunate.

Although large numbers of people are said to have tried marihuana, most of them have done so less than three times. They are included in many statistics in drug abuse. This is analogous to asserting that any young person who has taken a drink of alcohol is an alcoholic. Children will experiment with novelties if they are available. Most of them do not continue with their experimentation after they have determined to their own satisfaction that the quantity involved is not desirable. Unfortunately, unless they are made aware of the dangers of drugs, the drug environment and the penalties related to drug use, even experimenters can find themselves in serious trouble.

Possible Educational Approaches

Preaching and exhortation is an old and frequently used approach to "education." This may prove successful when the speaker is highly respected by his audience. It has, however, proven to be singularly unsuccessful with most American young persons — particularly high school students.

Drug education efforts frequently assume the familiar atmosphere of non-smokers and non-drinkers harangueing their friends who do not choose to abstain, about the hazards of lung cancer and liver damage. Very often the non-smoker and non-drinker are totally devoid of empathy for their smoking and drinking friends. Their nauseating condescention serves only to retrench their audiences' habits.

Much the same can be said about many teachers in drug education programs. Since they have never been a part of a youthful drug culture they cannot understand the needs and motivations which led their students to experimentation. When called upon to lecture on drug abuse, they tend to present a one-sided picture which conflicts with what many of the children think, do, and experience. Such an attitude can obviate any hope of educational success. Moreover, it backfires easily and often.

A person's strongly held beliefs and attitudes are rarely changed by an authoritarian, aggressive attack on them. Indeed, as often as not, such an attitude tends to reinforce the original beliefs and attitudes. A more balanced approach, which, instead of attacking a person's views, guides him to examine and reassess them himself, is more promising. Thus, educational efforts should present all sides of a given argument fairly, give all the known facts and aspects, and attempt to stimulate the student to play the role of the final arbiter — hopefully led by the educator to do so intelligently and with a sense of responsibility for his own well-being.

This is particularly true in the case of discussions concerning cannabis. When education degenerates into demogoguery, the teacher is attacking young America's sacred plant. Since the hazards associated with marihuana use are, in most respects, subtle and cummulative, overstated assaults on the evils of the drug produce alienation and cause students to believe that the teacher doesn't know what he is talking about. Educational efforts will seem unreal to the student since what is told to him does not fit reality as he sees it and has experienced it.

The same holds true for classroom instruction. Unless the teacher can present his topic in all of its aspects and dimensions, postive and negative, good and bad, desirable and undesirable, he will lose many of his students. Adolescents, because they are in a period of life where they search out and examine many issues which adults have come to view as settled, are very sensitive to lack of candor, to incomplete presentation of facts, and to biased attempts to lead them. They reject quickly, readily, and totally a source of instruction, be it a person or presented material, if they doubt its realiability, honesty, and sincerity.

The use of marihuana and hallucinogens such as LSD have become symbols of rebellion against established adult standards and authority. It is in the nature of rebellion that disapproval and repression strengthens and intensifies the movement. Excoriation of a young marihuana smoker or a prosecution of a petty drug offense could easily make these things seem even more desirable and important to some adolescents. These are some of the risks involved when one fails to understand the attitudes and values which are characteristic of teenagers.

Scientific facts, no matter how convincing they may seem to adults, often fail to persuade children. One reason is that facts, even when

learned, are viewed within the framework of existing motivation, feelings, and emotions. Facts that are in accord with what one already accepts, are accepted; facts that run counter are frequently rejected, quickly forgotten, or interpreted in such a way that they are more in line with what one wants them to mean.

Drug abuse classes are conducted for adults needing to know more about the drug abuse problem.

Clearly, then, knowledge of facts by itself does not necessarily change attitudes, beliefs, or behavior. Much depends on how and in what context such facts are presented.

As suggested earlier, direct attacks on people's attitudes often fail and actually arouse resistance. The harder the teacher attacks, the more obstinate and more extreme the student's attitudes become. But if influences are brought to bear on such a person more subtly and without his being conscious of being attacked, he will be more receptive.

Schools have many opportunities to do this. Long before formal drug education is offered more subtle influences could be exerted. For example, physical education classes offer many opportunities to insert references to the effects of drugs on physical fitness and attractiveness. Other courses could do the same. History is replete with illustrations of battles lost, empires disintegrated, leaders defeated because of indulgence in various detrimental health habits. Courses in biology allow references to the physiological effects of drugs.

If such educational messages are systematically planned with the cooperation of the entire school staff, attitudes could be created long before adolescence which could enable many children to resist temptations they will be exposed to during their teenage years.

Facts alone are not decisive factors in changing attitudes and behavior, but they could be if presented in a context that makes them meaningful. For example, statistics offered in the classroom on deaths attributed to drug overdoses will have very little impact on teenagers. On the other hand, an aggrieved girl telling the story of her boy friend's early death from an overdose would probably be very effective. In short, the more immediate and personal a demonstration is, the more effective the facts themselves become.

Another approach is the use of authorities such as physicians, or even ex-addicts, to discuss drug abuse. This is useful when there is little peer group pressure to use drugs. High school and college students rate physicians highly, but think law enforcement officials, ministers, and counselors are least convincing. For elementary school children, law enforcement and other institutional authorities rate higher. The use of police in the very early grades, as community members, has been found effective in creating an accepting attitude toward the law.

There is some evidence that many adolescents take up drugs not because they particularly want to or enjoy it, but because they consider it a mark of adulthood, or because they believe that it gives them some status among their peers, or in the eyes of the other sex, or because other teenagers talk them into it. Many of these young people may welcome the chance to give up drugs if they only knew how they could do it without losing face in the eyes of their peers or without surrendering some of the benefits.

These boys and girls would probably be quite responsive to any individual help that their teachers might offer. In some schools, notably on the West Coast, organizations have been formed which create an atmosphere in which the use of drugs is considered childish or stupid and is frowned upon. It is the function of this approach to provide students with an alternative life-style which is anti-drug. This approach can be seen in the work of Mr. Richard G. Christensen, Director of the Creative Life Foundation in Seattle, Washington. His program seeks to supply youthful members of the Foundation with alternative forms of music, clothes, and even food. A more complete discussion of Mr. Christensen's efforts can be found in Chapter 12 of this Report.

If organizations such as Mr. Christensen's Foundation can be made attractive and prestigious in the eyes of enough students, those

who do not choose to use drugs in the first place and those who are eager to shed such habits can find a congenial peer group which provides them with a satisfying quantum of social reinforcement.

There are many students not engaged in drug abuse, but are on the verge of yielding to the temptation to indulge. Psychological research has found that during this period of indecision, almost any influence may suffice to swing the decision one way or another. Well-structured peer group pressure may have a decisive influence on this group.

Lastly, there are the young persons who are already captives to their drug habits. They may already have become habituated and are acutely dependent on marihuana and other drugs. Some of these may be totally adamant to any attempt to change their habits and lifestyles. Unfortunately, many of these may already be beyond help from an educational standpoint. But others may respond to intensive peer pressures supplemented by individual counseling or from limited forms of psychotherapy.

A constant problem is the difficulty of making classroom learning relevant to the student's outside life in order to provide for a carry-over to the latter. A major reason is that many children (particularly those who represent the most difficult problem cases) see the classroom as a world separate from the real world in which they live.

Since this image is difficult, perhaps impossible to change, in many cases it may be easier to change the entire learning situation. A teacher might, for example, consider a discussion group approach instead of the more typical approach of the classroom and move from the classrom setting to more informal surroundings. The teacher might also make himself available for spontaneous group discussions which are completely removed from the classroom. Such discussions might occur on a regular basis in homes, in fraternity houses or dormitories, or in other places which do not have a "school atmosphere." The teacher or other experts could function as resource persons while the discussions were lead by students themselves. In fact, many authorities agree that the more closely both the physical environment of the style of instruction maintained in such groups resembles situations in which young persons usually move, and in which they are exposed to undesirable influences which education seeks to counteract, the more effective the discussions are likely to be.

Group discussions, pro and con presentations, and so-called sensitivity training sessions can be used in certain limited circumstances, but must be used with extreme caution. In pro and con discussions, even a single hostile response by the instructor can affect the entire program. Small group discussions with knowledgeable people have the best potential. Large lecture type assemblies are of little or no value for young people.

The effects of television and radio drug advertising on young children creates an added atmosphere of acceptance of the idea that "taking something" will solve personal problems as well as treating illness and discomfort. This "education" by the mass media must be continuously counterbalanced by parents and schools.

Educational Programs

The role of the school and of the educator in handling the problems of drug abuse is frequently ill-defined. Many states, including Illinois, require the teaching of drug abuse in public schools but leave the implementation of such teaching up to the school directors. Thus there is a wide variety in what is taught, the amount of emphasis that drug abuse is given, and in the amount of understanding with which the teaching techniques are employed.

There are a number of school-developed and commercial programs in use today. Their effectiveness is not known since most of them have only recently begun. The U. S. Office of Education has initiated a multi-million dollar program for teacher training intended to train 150,000 teachers. Private organizations such as the JayCees, Kiwanis, National Association of Retail Druggists, American Pharmaceutical Association, National Coordination Council for Drug Abuse Education and Information, and many others have programs. The White House itself has a ten point program for coping with the drug abuse problem and has established the National Clearinghouse for Drug Abuse Information, which provides similar information on request, but which also provides the school director copies of school curricula.

The Bureau of Narcotics and Dangerous Drugs works with school and teacher training programs and provides similar materials and consultative assistance through its national office. It also conducts special programs for community action on a pilot basis, to develop local action committees for drug abuse prevention.

Marihuana is smuggled into the United States in such items as dolls.

When closely inspected, this Japanese doll was discovered to contain marihuana in the neck and body section.

Focal Grade Levels

The ideal drug education program should be included naturally within a science or health curriculum in a long-range program in the total kindergarten to twelfth grade experience. As indicated above, references to drugs can be interspersed through many subjects. Most educators, however, agree that the science and health curricula are the most opportune vehicles for imparting knowledge about drugs. Attitudes and values must be part of the program from the earliest grades. Key concepts in the early grade school years is that "only sick people need drugs" and that these drugs are beneficial to man and should not be abused.

Research has shown that fourth, fifth, and sixth graders have a tremendous curiousity about the drugs they have constantly read about and heard about via the mass media. Many teachers have reported that children in these tender years are well-versed in drug terminology and frequently ask questions which are as sophisticated as those one might expect from a high school student. Effective beginning instructional programs for these students have often included basic data about drugs, presented in pictorial or cartoon form.

Instructional Techniques

The problem of drug abuse reaches deeply into our values, aspirations, and fears. It is an emotionally-charged area of great concern to most people. Teachers are continually facing the difficult tasks of deciding appropriate techniques to use in teaching about drugs. Establishing an atmosphere conducive to good communication between teacher and students is of basic importance. The instructor should strive to find ways in which he can strengthen his relationship of trust and understanding with students and open up dialogue and discussion.

Teachers are in a particularly good position to encourage parents, students, and the community to remain level-headed about drug abuse. If a teacher has reason to believe that one of his students is experiencing serious emotional difficulties, consultation should be sought with the school counselor and a conference arranged with the parents with a view toward obtaining professional help for the young person involved.

While the teacher can play a role in referring suspected problems to the proper authorities, a panic reaction expressed either to the student or to the parent can serve only to alienate the student further and to confuse what should be straight-forward, objective, and professional action if the student needs help.

Encouraging an atmosphere in which the student feels free to confide in parents and teachers in discussion is an important first step. Obviously the size of the classes today often makes personal contact difficult. At the same time, if the student realizes that his parents and teachers are making a genuine effort to understand his point of view, this realization is likely to help him in the process of maturing. Although it is sometimes difficult, it is important to avoid being moralistic in talking about drugs and drug abuse.

As stated previously, the use of sensational accounts or scare techniques in trying to dis-

courage drug experimentation is usually ineffective since the teenager's direct knowledge frequently contradicts them. Teenagers demand, and are entitled to honest and accurate answers. It is impossible to eliminate or legislate away all possible circumstances of abuse. The individual decides for himself whether to use or not to use drugs. To be effective, presentations ultimately must be based on each student's decision not to use drugs because they are incompatible with his personal goals.

Some teachers, like many parents who are anxious to discourage drug abuse, are likely to assume that *any* departure from the preferred styles and customs of the majority is indicative of drug abuse. By equating unconventional appeals with drug abuse the teacher may inadvertently encourage the very behavior he is trying to discourage. At a minimum the young man or young lady is likely to feel that the conventional world is completely opposed to any originality or creativity that does not fit the mold, and that the price of acceptance is complete conformity. External appearances may conform to the norm and still be no assurance that drug abuse will not become a child's private mode of rebellion.

It is extremely important that teachers not fall into the pitfalls of creating stereotypes for drug users and pushers. The evidence suggests that the vast majority of young people who experiment with marihuana do so on a one time experimental basis. Drugs differ widely in their chemical composition and in their effects — depending upon the personality of the user and the circumstances of the use. The person who misuses drugs may vary from the one-time user, experimenting out of curiosity to the chronic heavy user who is psychologically dependent on the drug. Some types of drug misuse may be apparent even to the casual observer. Other types may be so subtle as to escape the detection of even the experts.

It is crucial that before beginning any instruction on drugs, the teacher should be well informed about his subject matter. It is especially important that the instructor be particularly well informed on the various major issues in the drug field such as whether marihuana should be legalized and how marihuana compares with alcohol and tobacco in terms of harmfulness.

Drug education materials can be of great value if used as a springboard to discussions. Pamphlets and other materials need to be personally relevant to students. Teachers skilled in classroom discussions are well aware that much of the art of effective discussion requires that the instructor be a thoughtful and responsive listener as well as a catalyst.

Lastly, the adult teacher can serve to demonstrate that it is possible to live an involved, truly meaningful life without the use of chemical substances to add meaning or excitement. The adult who is himself "turned on" by life itself without recourse to drugs, is one of the best advocates for that type of life.

Counseling Services

In addition to a purely educational approach to drug abuse it is extremely important that schools provide adequate counseling services to students—particularly at the high school level. The counselor can have a great influence on the decision to take or continue to take drugs. He is often the confidant when parents are lacking or have failed to accept their role. The teacher or counselor may be the first to learn of, or notice aberrant behavior due to drugs. He may be able to persuade his pupil by presenting factual information.

In general it is advisable to have a strong liaison between teachers and counselors in the drug area. In many schools it is preferable to have teachers who present drug information in the classroom to double as counselors. The thinking is that the expertise displayed by the teacher in his classroom provides a logical premise for a student with a drug problem to confront him outside of class in his office.

It is extremely important, in any event, that some member of the faculty or staff be well known among the student body as a friendly, understanding advisor in drug matters. As is the case with drug education teachers, it is imperative that the counselor be someone that the students can "believe in." In his new book, *Overcoming Drugs: A Program for Action,* Dr. Donald Louria asks for an ombudsman approach to drug education in schools: a teacher nominated by the students and then specially trained for confidential counseling and referral of students involved with drugs. In Louria's view, this assignment must be sharply separated from the school administration's role of detection or punishment of drug abuse among students.

The question of confidentiality is rarely an issue, but adequate provisions must be made. If a student approaches a teacher as a friend to discuss his drug problem, he must be warned about the teacher's duties in the matter. It is to be hoped that it will be possible to listen without disclosing, but school regulations may prevent this. Under such circumstances the stu-

dent must be clearly told beforehand. A certified school psychologist or psychiatrist has the advantage of being able to keep his patient's statements confidential as privileged communications. Referral to such a person will safeguard the student.

Regulations Against Drug Abuse

It seems reasonable to insist that usage or trafficking of any illegal drug not be permitted on school grounds. Furthermore, psychological dependence upon mind-altering psychedelics, stimulants, sedatives, and intoxicants is contrary to the goals of the educative process, whether excessive use be on or off campus. If a place of learning is where one's intelligence, capabilities, and skills are enhanced, then habitual displacement of consciousness, reality testing, and reasoning ability is antithetical to its goals. The frequent use of any drug can result in impaired performance in scholastic endeavors. Indeed, a single use of some drugs is associated with a temporary decrement in psychomotor functioning.

In schools where the administration believes that no drug activity is present, there may be reluctance to "rock the boat" by opening up the subject. The likelihood, though, is that more drug activity is going on than comes to the attention of the authorities. It is of the utmost importance that all junior and senior high schools establish a policy of what shall be done about blatant drug abuse and illicit traffic on the campus.

It is in peer groups that drug abuse spreads. The teacher may become aware that one or a few individuals are proselytizing. An epidemic may be prevented by quick action in such instances by reporting these students to police drug and juvenile authorities. At the very least, school authorities should make the campus a difficult place to obtain or use drugs. It is too much to expect that school authorities be made responsible for activities off the school grounds. Yet they hold the key to controlling the drug experience of hundreds of children at one of the most significant junctures of their lives.

A repertoire of disciplinary measures with some built-in flexibility is preferable to rigid, mandatory punishments. The campus supplier or LSD and methedrine is not in the same category as the youngster who has been persuaded to try some "grass" and whose negligence has resulted in his detection.

Institutional policies and regulations form an extremely important control mechanism in regard to the use of dangerous drugs on the college campus. It is suggested that these policies should always be firmly and clearly presented in every possible form of communication to the student body. The trap of ambiguity should be carefully avoided. Young persons are particularly sensitive to hypocrisy, bigotry, and dishonesty. These vices are particularly irritating to young adults in college. In many, the struggle to build a better world involves a continuing analysis of the regulations which confine his behavior. Dr. Dana Farnsworth has emphasized that the application of punitive sanctions at their period in the development of the personality may only perpetuate undesirable behavior and make rebellion more intense.

Drug Education in Illinois

Under the School Code of Illinois instruction on the nature of alcoholic drinks and other drugs "and their effects on the human system shall be taught in connection with the various divisions of physiology and hygiene . . . in all schools under state control or supported wholly or in part by public money . . ." Ill. Rev. Stat. ch. 122, § 27-10 (1969). The Code goes on to require such classes in grades four through nine the use of "suitable textbooks" with not less than four lessons a week for ten or more weeks of each year. Children in the first three grades must be "instructed in this subject orally for not less than three lessons a week for ten weeks in each year, by teachers using textbooks adapted for such oral instruction as a guide and standard."

The School Code also states that, "In all state universities and teachers' institutes, adequate time and attention shall be given to instruction in the best method of teaching [about drug abuse] and no teacher shall be certified who has not passed a satisfactory examination in this subject and the best methods of teaching it." Finally a fine not to exceed $25 is specified for any school officer who fails to comply with the Code's requirement.

Thus far, implementation of the Code's requirement has been sporadic at best throughout Illinois. Each county school superintendent is given the prerogative of deciding what mode of drug instruction shall be given within his county. In most cases this has been minimally defined as the responsibility of choosing a uniform manual of instruction for use throughout the county. In Cook County, for example, the School Superintendent has selected a $4 teacher's guide put out by the American School Health Association. During the past year three "work shops" have been held on drug abuse.

It is generally agreed that these encounters have been beneficial to both the students and school officials who have attended. A recurrent message received from the students has been a consistent rejection of scare tactics. In most meetings young persons have urged school authorities to present only the facts about drugs and let each person reach his own conclusion. At one conference the discussion turned to the much publicized suicide notes left by persons involved with drugs. Most of the students said they and their friends had not been impressed.

Most of the students at the high school level who attended the work shops reported that marihuana and other drugs are readily available to them and have presented a growing problem in their schools in the last two years. Some said the problem would be greatest among those who are now freshmen or sophomores because they are growing up in the "drug generation."

The students said they think most youths who turn to marihuana and other drugs are experimenting. This view is validated by most research on the subject. Some youths feel pressures to go along with the crowd; others use drugs because they feel left out. According to one girl, "Some people just don't care what happens to them. They shoot up and they just don't care."

Many students recommended that drug information programs be started early. "The time to start is back in grade school and not with this stuff about 'marihuana is evil,' " one youth said. "That just turns everyone off. You've got to present the case and let the person decide for himself."

The students urged give-and-take programs on drugs and recommended talks by experts who would present case histories rather than lectures. They agreed that programs should be arranged by students, not by administrators or outside community groups "who really turn the kids off." Some of the students said their schools had no drug education programs at all.

Because of the lack of uniformity and the expense, state school officials have prepared a teacher's manual for drug education. The project will save the state more than $100,000 since it will no longer be necessary to purchase manuals from private publishers.

The state manual was prepared by 18 representatives of the Office of Public Instruction, the Department of Mental Heath, the Illinois Bureau of Investigation and the Governor's Committee on Human Resources. The project was funded by a $15,740 grant from the Illinois Law Enforcement Commission.

To supplement formal instruction some school systems have utilized field trips to broaden the student's understanding of the drug problem. One encouraging program is that started by Chicago School Superintendent James Redmond. An accredited course in social studies has been set up in 17 Chicago high schools. The students themselves organized the format of the course. Drug abuse is heavily emphasized. Visits include a stop at a Chicago drug rehabilitation center where students are free to "rap" with addicts in an effort to understand the root causes of drug abuse.

The New Trier Experience

In November 1970, the Commission learned of the death of a 14 year old Glencoe girl named Lisa who died of a drug overdose. Lisa came from an upper middle class family and was a freshman at New Trier East High School, one of the best high schools in the country. She had never been in serious trouble with the police and by all appearances seemed to be a perfectly normal teenager to teachers, school advisors, and her family doctor.

Her friends, however, had noticed a change in Lisa over the last year of her life. According to a classmate who went to school with Lisa, "She was a nice kid, a real nice kid, but she was a freak. I don't like to use the word 'hippie,' but that's what she was. You could tell she was on drugs. A lot of people use drugs around here, and she was one of them."

Others of Lisa's age who knew her confirmed that recently there had been a noticeable difference in her manner and appearance. Lisa, a typical, sociable school girl at one time, was rarely seen at dances last year and seemed to be withdrawing from her classmates. She adopted a careless appearance and usually wore checked flannel shirts, baggy pants, and desert boots.

The changes were never enough, however, to attract notice to herself or to make her stand out to teachers and administrators as having a drug problem. The Glencoe police were aware that Lisa had occasionally used marihuana and barbiturates. But the contacts she had with the law were insignificant, said Glencoe Detective David Sharpe, compared to many other youths in the area

The body of the girl was found in her bed by her father after Lisa failed to respond to her alarm clock for another day of classes at New Trier East. Ironically, had drugs not claimed her life she would have attended the last of 12 daily

classes on the dangers of drug abuse for New Trier freshmen.

Further irony was provided by the fact that Lisa's tragic death occurred on the day of a funeral of a boy who had killed himself because drugs "ruined his life." (See Chapter 2.)

Because of the ironic circumstances of Lisa Humphrey's death, and because it typifies the sort of tragedy which has become a daily phenomenon in the United States, the Commission looked further into the details of the case. This testimony was elicted from Mr. Earl Weingartner, Director of Student Services at New Trier East High School and his assistant, Mr. Richard F. Hangrin, as well as Captain Robert Bonneville of the Glencoe Police Department who testified at the Commission's December, 1970, hearings into the Drug Revolution. Their testimony is summarized in Chapter 17 of this Report.

The Commission was particularly interested in New Trier's approach to drug education. The two high schools located in that township have traditionally been leaders in innovative approaches to education.

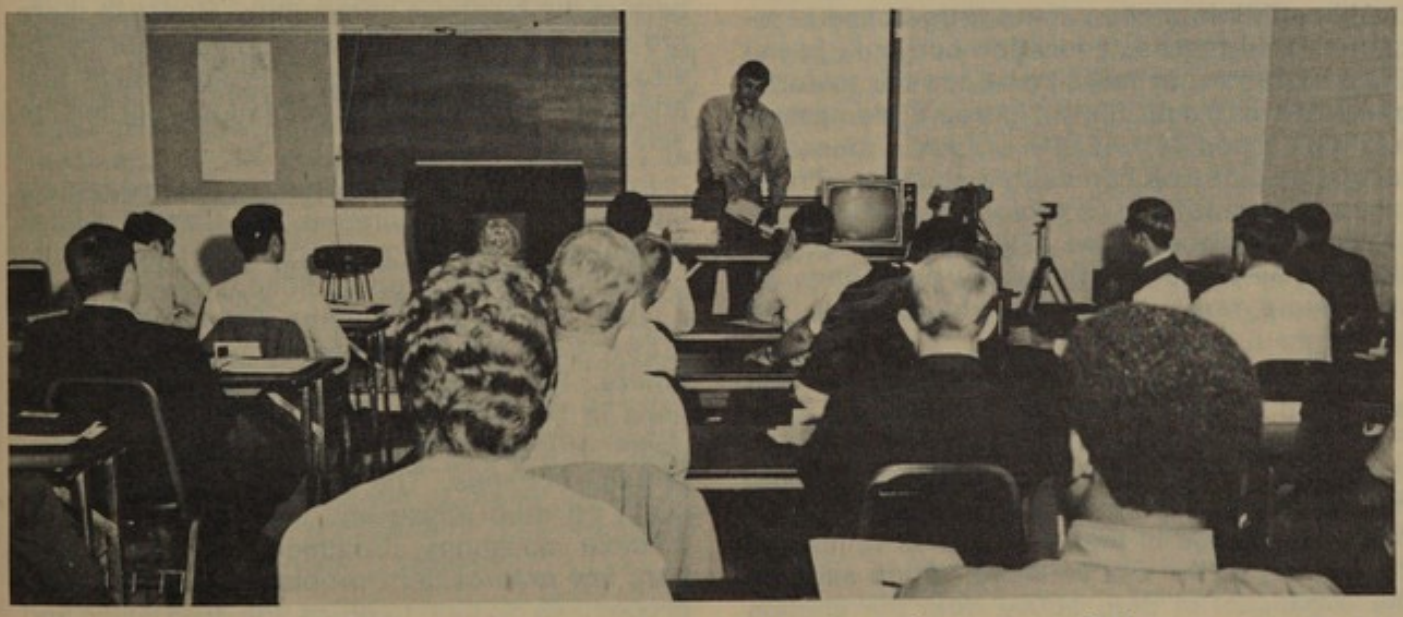
In December, 1967, a meeting was held with members of the administrative staff and members of the Board of Education to discuss the growing drug problem. The outcome of the meeting was to establish policies and regulations concerning actual drug violations on campus, to set up individual counseling efforts in the drug abuse area and to study possible means of educating students and parents about drugs.

In the summer of 1968, a committee developed a course in "Human Behavior" in which drug education would be a significant part. This course is an elective minor and was begun in the fall of 1969.

In February, 1969, a large township-wide evening program was conducted entitled "The Township and Drugs." Adults and young people met in small groups in rooms in various schools throughout the township. The first half of the program included a closed circuit television presentation by a panel consisting of several school officials, a police official and several men who had worked in the field of drug abuse education. This was then followed by group discussions in each of the small rooms.

It is estimated that about 7,000 adults and young persons attended this meeting. Reaction was mixed, but many, especially the adults, gained new perspectives on the implications of the drug crisis. People were encouraged to send in questions, which were answered by telephone, letter, and on a series of programs on WNTH, a local FM station.

During the winter and spring of 1969-1970, talks were initiated with members of community groups in elementary school districts in the Winnetka vicinity. In the summer of 1970, the Board of Education authorized the establishment of a committee on drug education. One of the accomplishments of this committee was the creation of a unit on drug education. This unit is now taught to all freshmen in physical education classes. In addition to this specific class, some aspects of drug education are considered in other courses such as Human Behavior, Bio-



Classes in drug abuse problems are conducted throughout the state so that more persons are aware of the problems and are well informed on the subject.

logy, Chemistry, Child Development, Driver Education, and some English classes in connection with literature and writing assignments.

In his testimony, Mr. Weingartner noted that the school is only one agency in the community which needs to be involved in drug abuse education. To obtain greater community-wide involvement, Mr. Hangrin, Chairman of the Committee on Drug Education, is presently engaged in discussions with representatives of various civic organizations in the villages which make up the New Trier school district.

Some parent groups are planning to study a modified form of the basic course given to the freshmen. Several members of the New Trier East staff are preparing a course for adults which will be offered in the adult evening school.

It is the Commission's conclusion that the inroads made by New Trier are exemplary. We believe that a substantial improvement could be made in many programs throughout the state if local school districts would express the sort of concern and dedication we observed in the Winnetka area.

Professional Education

As intimated above, most primary and secondary teachers in Illinois are ill equipped to teach about drugs. In most cases, they have not received sufficient training themselves and do not have adequate course outlines.

Intensive teacher education is essential if instructors are to respond to children's questions with certainty and assurance, avoiding the exaggeration, distortion and sensationalism that nullify effectiveness of educational efforts.

Although information about drug abuse is required in all teacher education curricula in the State of Illinois, in most instances the material presented is insufficient to prepare elementary and high school teachers to present a meaningful course of instruction to their students. Training is usually within a sociological and psychological framework. The full spectrum of the drug abuse crisis and the many disciplines involved are rarely effectively presented to the teachers.

Teachers should be informed on what is fact and what is non-fact in the drug abuse area. For example, a tremendous degree of expertise is required in the many arguments surrounding marihuana use. Instructors should also have a basic knowledge of the many trends which are developing in the use of illegal drugs such as the expansion of drug abuse from the ghettos into affluent suburbs. Other areas, in the nature of specific warnings, should be well understood by the teacher. Examples include the high hazards of using amphetamines and the high risk of arrest when dealing with illicit drugs.

In addition to specific couses it is extremely important that teachers maintain a current knowledge of drugs by keeping up with books and other literature concerning drug abuse. Although it is difficult to obtain current information about which drugs are being abused by young people, it is extremely important that teachers do so. Since the drug scene is a constantly changing phenomenon, timely information is an absolute prerequisite to communicating about drugs.

In addition to teachers it is important that all disciplines involved in the drug problem receive adequate training about drug abuse. This is particularly true of the medical and paramedical professions which are continuously involved in counseling situations with patients who require information about drugs. Since 1963 significant progress has been made in developing courses on drugs in schools offering instruction in the study of human medicine. In addition to the pure pharmacological aspects, emphasis has now been placed on the sociological and psychological aspects of drug use. It is the Commission's hope that this commendable trend will continue in the future.

In addition to persons in medicine and education there are many other professional areas which can benefit greatly by improving their understanding of the drug problem. Examples include counselors, the clergy, social workers, representatives of law enforcement, and members of the business community. Because there are so many individuals who could profit by instruction on drug matters it is imperative that adequate professional educational programs be established.

In the Commission's opinion, an exemplary undertaking in this area is the Central States Institution of Addiction Programs. The Institute conducts a seminar on addictions several times a year. Students attending the program are drawn from all of the above professions and others. The seminar is taught at various locations in Illinois. The seminar's faculty is composed of leading authorities on drug abuse and related problems. The lectures include discussions on drug abuse and the educator, sociomedical questions, treatment and rehabilitation, law enforcement problems, state law and procedures relating to drugs, the drug traffic and many other pertinent areas. The Institute is located at 126 N. Des Plaines Street, Chicago,

Illinois. It was conceived in 1963 through the initiative and inspiration of the Reverend Monsignor Ignatius D. McDermott, Associate Administrator of the Catholic Charities of the Archdiocese of Chicago. The institute is endorsed by the Illinois State Medical Society and recognized by many educational, health, welfare and enforcement agencies on a local, state, and national level.

The Institute was founded on the recognition that large gaps of knowledge and skills exist within the professional communities in the area of chemical dependencies. Given the premise that the numerical impact of the professional community upon the general population is enormous, the Institute logically concluded that these professionals hold a vital community status and their education is incomplete unless it covers the many facets of chemical dependency. The Institute has endeavored to meet this challenge of education and training in the area of alcohol and drug abuse.

The primary objective of the Institute is to provide to the professional disciplines and to the community at large a highly informed professional person. This professional will carry his impact to his peers, to the community at large and to the patients, students and clientele that are the subjects of his discipline. Additionally, the stimulation of the informed professional will provide added interest and inquiry into the area of drug abuse so that all disciplines may devote a greater percentage of their time and effort to this problem. The Institute also aims its efforts to the general adult public so that acceptable knowledge and skills will be available to parents and others in addressing themselves as individuals or community organizers to the drug problem. Lastly, the training and education offered by the Institute provide a solid base of knowledge and skill wherein the treatment and health service professionals may be prepared to treat the victims of this social problem on a clinical level.

The seminar utilizes all standard audio-visual instructional aids. The two principal methods employed are the lecture, question and answer period, and the utilization of group dynamics. The group sessions are approached not only from a theoretical standpoint but the methods of dynamics themselves are practiced in laboratories under the tutelage of highly skilled instructors. All lecture material is fully integrated with the group dynamics sessions.

Additionally, the library and laboratory of the Institute are available to every student for further research into the literature and observation of the actions of chemicals upon animate and inanimate things. Both of these resources are available to each student as part of his instruction.

The Institute is divided into two sections. These are called the Alcoholism Section (A), and General Narcotic and Drug Abuse Section (GNDA). Each section offers three courses of instruction. Each course builds upon the other logically, going more deeply into each discipline. Since these courses are in sequence they are open to registrants only in that order. Each course currently offers 50 hours of fully accredited instruction and carries five quarter hours of the upper division undergraduate or graduate level. Successful completion beyond the beginning levels is dependent upon the results of a written examination administered by the Institute.

The Addiction Institute is the training agency for drug education teachers in the Chicago public school system. The first citywide drug abuse program began this fall for students from kindergarten through senior high schools.

Following a random survey of 10,595 students last April, the Chicago Board of Education decided that there was a need and a desire for drug education in the city's schools. An initial group of 79 teachers were selected by the Board for an intensive training session this summer by the Institute. These teachers are now serving as resource people in each of Chicago's 60 high schools and 19 upper grade and vocational centers. Almost 90 per cent of the teachers have had training beyond the bachelor's degree level. They have continued teaching their regular course material for physical education, social studies and sciences in addition to providing drug information for the students. According to Dr. Lorraine Sullivan, Curriculum Director, each teacher has been given the option of working out the individual school's approach to the drug curriculum guidelines in cooperation with the principal and the staff.

The Commission's Executive Director and Chief Counsel were guest lecturers at the Institute's summer seminar for the summer 1971 class that included the 79 Chicago teachers.

The Media Approach

In addition to formal educational programs in the schools and private institutes, much can be done through public education by the mass media. In the course of its research the Commission was both encouraged and disappointed by the efforts made by the mass media in the drug area.

We look with great uneasiness at the proliferation of advertising for non-prescription stimulants and sedatives. In our view, this sort of advertising encourages the furtherance of a drug dependent society. It is ill advised to encourage the use of stimulant tablets for persons who are "tired and overworked." Similarly, it is wrong to suggest that one requires a chemical crutch if he can not get to sleep in ten minutes. These advertisements, along with the deplorable increase in pain reliever ads, have done much to promote hypochondria and drug dependence as an American way of life.

In a somewhat different vein, many of the efforts undertaken by the media in the area of drug abuse have frequently been mis-directed, understated and stereotypic. There are, however, many exceptions to this. A number of documentaries, particularly some of those produced by Columbia Broadcasting System, have been of unusually high merit. The sort of in-depth research and preparation practiced by CBS should be a model for other national networks and local stations.

One local station which has been a leader in the fight against drug abuse has been the WGN Continental Broadcasting Company of Chicago. The Commission and the General Assembly, through a resolution, has congratulated WGN in its fine efforts against the narcotics and dangerous drugs problem.

In the process of isolating community problems and determining community needs, WGN placed top priority on the drug abuse problem among youth. During 1970 the network conducted three major campaigns on the subject.

In the spring of 1970, WGN Television presented a concentrated eight day alert campaign to warn those individuals, especially the youth of the community contemplating the use of drugs, of the inherent dangers of "turning on." In June, 1970, WGN Radio, participating in a combined effort of Illinois Broadcasters Against Drug Abuse, presented a month-long program of special broadcasts, editorials and messages by well known sports personalities.

Because of the widespread response to the two previous campaigns, WGN-Radio and WGN-Television in a joint effort launched a dramatic extension of the drive with the beginning of the school year in September, 1970. The concept, plan and creative materials were produced by WGN Continental's advertising agency, Foote, Cone, & Belding working in cooperation with WGN's Program, Public Affairs & Public Relations & Advertising departments.

"Cold turkey isn't something you eat" was the blunt and provocative theme of this extensive joint effort. The expression "cold turkey" has become the trade mark of this hard hitting campaign from coast to coast and in many countries.

For the greater Chicago Area served by WGN-Radio and WGN-Television, the effort again involved all-out programming on the subject: saturation schedules of special announcements offering a free packet of literature to the public, interviews, discussions, special program features, and meaningful editorials.

This campaign was augmented with a series of four startling full page advertisements that were placed in Chicago's four daily newspapers. Single insertions were placed in several other publications in the area such as *Commerce Magazine* and the *Chicago Defender.*

The campaign was also supplemented by a series of three dramatic posters designed for display in gathering places for young people. A total of more than 350 poster sets were distributed to high schools by the County Superintendent of Schools. Posters were also distributed through the YMCA and other youth oriented organizations. Many more were distributed in response to requests from schools, teachers and students. Further information concerning the WGN program may be found in Chapter 16 of this Report.

Similar drug messages on television and radio have recently been programmed by other stations. The Commission is particularly encouraged by the brief drug messages on radio rock stations such as WLS and WCFL-AM and WDAI and WBBM-FM. These short segments are succinct and thought-provoking yet do not carry an aura of propaganda. In many, rock music and frightening electronic sounds which duplicate the sounds and sensations of the youthful drug culture are used. The effectiveness of these ads is enhanced by the fact that most listeners are under age 25. This also represents the age classification of the majority of drug abusers in the United States.

The latest commendable drug education effort was the public affairs program "Mainline," sponsored by WNUS Radio of Chicago in cooperation with the Illinois Drug Abuse Program (IDAP), and the Kemper Insurance Group. The series started on August 21, 1971 and will be simulcast every Saturday on both WNUS-AM and WNUS-FM for nine weeks. WLS listeners will have the opportunity to participate via telephone following the main discussions.

The WNUS news release stated the program:

. . . will probe the causes and effects of drug abuse and examine the treatment and rehabilitation programs of the IDAP.

. . . It will be directed toward opening new lines of communication between our audience and qualified people from agencies recognized for developing successful anti-drug programs, in the hope that positive, constructive ideas and information will be developed. If we can help our audience understand the problems of the drug problem, and how to deal with them, we will have really accomplished something. . .

In addition to drug segments on radio and television, newspapers throughout Illinois have done much to focus public attention on drug abuse. Several newspapers now have reporters who are assigned chiefly to drug matters. Moreover, many newspapers such as the Chicago *Tribune* have carried continuing feature articles of a very informative nature on drugs. Newspapers have also carried advertisements sponsored by concerned businesses such as the Osco Pharmacies in Chicago.

As indicated above, many civic organizations such as Kiwanis and the JayCees have made significant contributions to public education about drugs. For the most part their efforts have been channeled through various media and through pamphlets and other handouts which are intended to warn the reader about drug abuse. A good example of this dissemination can be seen in a pamphlet distributed by Chicago Realtors Against Drug Abuse entitled "A Look at Drug Abuse." The small handout contains helpful information about marihuana, LSD, amphetamines and barbiturates.

Private businesses have also begun to contribute to the anti-drug campaign. One recent example is a billboard advertisement promoted by the Oakridge Glen Oak Cemetery which reads: "If you use it . . . [depicting a syringe used for injecting narcotics] YOUR LAST TRIP Could Send You To Us." This poignant message underscores the lethal toxicity of narcotic drugs and demonstrates the social concern of its sponsors.

Government has many opportunities to promote drug abuse information. At the federal level, the Bureau of Narcotics and Dangerous Drugs has been a leader in supplying publications, speakers and films to persons and groups seeking information. On a smaller scale, the Illinois Bureau of Investigation and the Chicago Police have done much of the same in Illinois.

The new Law Enforcement Assistance Administration (LEAA) has done much to foster educational programs. A leading example is project "Straight Dope." The project started in Illinois and was funded by the Illinois Law Enforcement Commission, the State planning and distribution agency for LEAA funds. The program involves numerous visual aids which have high impact on youthful drug abusers. Copies of the ads have now been circulated among numerous other states.

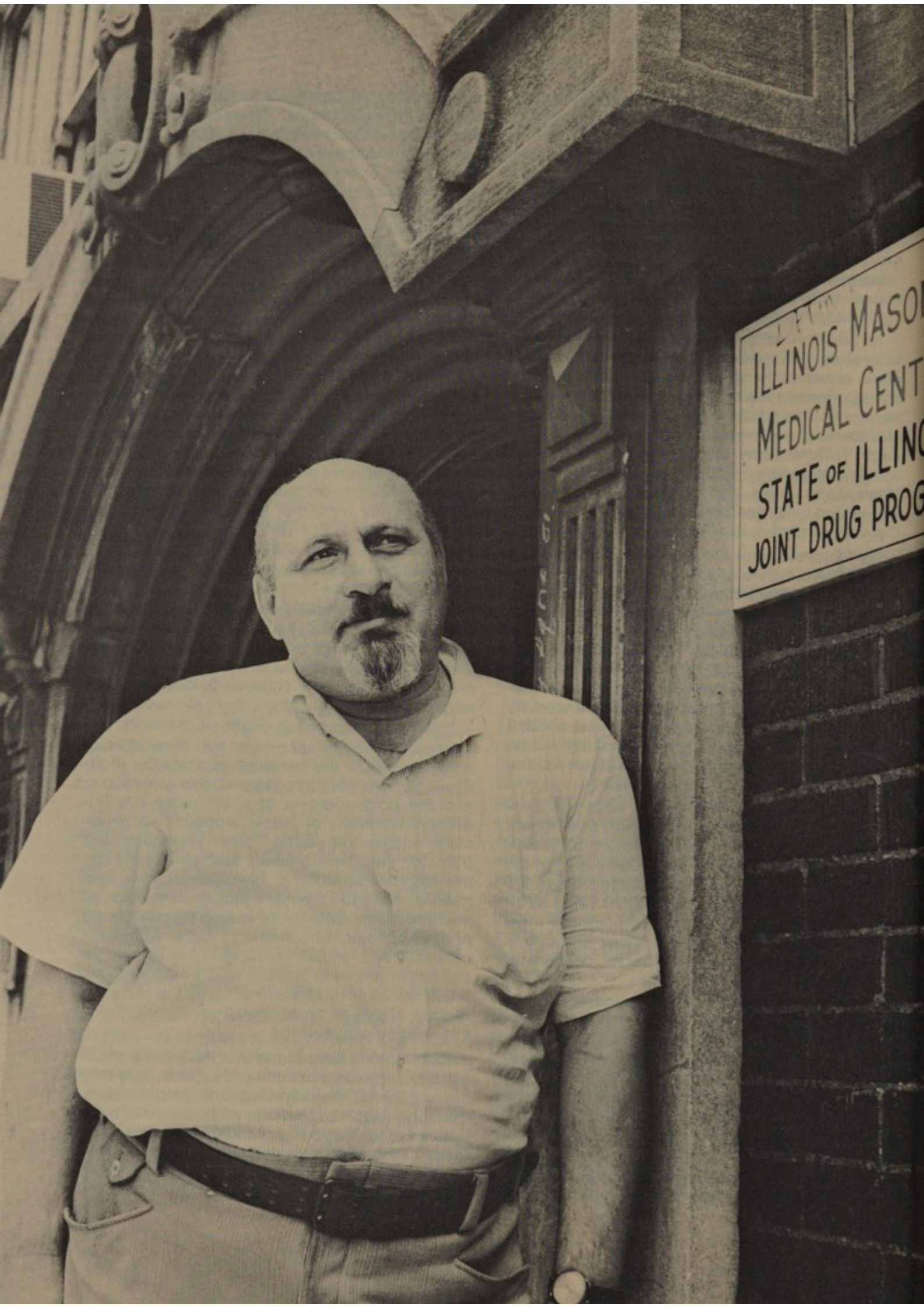
Conclusion

A scrutiny of the past suggests that drug abuse tends to be cyclic, with a rise and fall which is not clearly perceived except from a distance. The proposition that we have experienced periodic surges and declines in drug-taking behavior is no plea for complacency. An active effort to teach the individual and society how to enjoy and endure without euphoriants and escapants is essential. Setting the drug abuse problem in an historical perspective simply avoids the myth that the quality of life is at its lowest ebb. This myth happens to be prevalent among the drug subculture. It displays a profound and potentially disastrous ignorance of the history of man.

Education of Illinois' youth is education for our state's future. In the year 2000 today's two-year-old will be a mature adult. The parents and teachers of today as well as government and the media must help our children to depend upon personal resources rather than chemicals, for courage, insight, and a sense of purpose.

Personal control of one's attitudes, values, and conduct is the measure of maturity. Self-discipline, the ability to assess one's own moods and the postponement of gratification are important indicators of proper emotional development among the young. Their education and training, their environment and circumstances are responsible in large measure for how they mature. Parents, teachers and communities all share the responsibility for seeing that the young people in their care learn to cope with their personal and social conflicts. The quality of our future depends on how well we accomplish this. Recent statistics which verify the increase in drug abuse as an escape from responsibility are an ominous warning.

Researchers have found that many drug abusers have problems in setting life goals, that they are apathetic, disinterested and tend to withdraw from society. Parents and educators must find ways of developing interests, values, attitudes, and life goals for children so that the "drug scene" is not more appealing to them than their daily lives.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Chapter 9
TREATMENT AND REHABILITATION

Introduction

The misuse of drugs is a social phenomenon which has existed since the beginning of recorded history. Accounts of self-induced euphoria are found as far back as in the writings of Homer and in archeological remains of the ancient Inca civilization. More recently, the misuse of drugs has been significant in numerous historical events, such as the Opium War between England and China, and the plague of morphine addiction which followed the Civil War in the United States. Notwithstanding such tragic milestones, in all history there has never been a trend of drug abuse comparable to that witnessed during the past decade.

As discussed in other chapters of this Report, since the mid-1960's the abuse of drugs has spread from its traditional repose among the ghetto poor to the suburbs, the college campuses, and to every stratum of our society. Unfortunately, prior to this sudden and explosive growth there was insufficient interest or concern for developing adequate treatment and rehabilitation programs especially in large metropolitan areas where the addiction problem was acute. Society was satisfied if addicts were simply isolated from the masses and left to their own resources. Consequently, the crisis of the sixties was met with a poorly developed epidemiology, and the scientific process for devising effectual treatment and rehabilitation programs began with little foundation.

In the past 8 to 10 years, many theories of drug abuse treatment have been propounded and tested, some with more success than others. These projects have been supported by both public and private resources. Sometimes this recently-aroused concern assumed the dimensions of hysteria, and funds were allocated for proposals which reflected considerable hope, but few prospects for success. Eventually, however, a number of fundamental approaches to the situation were evolved as the nature of the problem became less of a mystery. This chapter describes these fundamental approaches, and the efforts undertaken in the

State of Illinois to provide treatment and rehabilitation services for drug abuse.

It is important to emphasize that several treatment modalities have gained widespread use over the past few years. Unfortunately, neither their volume nor their effectiveness have kept pace with the rising tide of drug addiction and dependency. Perhaps, worst of all, there has not been an accurate way of gauging the successes or failures of these programs or the likelihood of accomplishment for a given addict. According to the renowned Dr. Nathan B. Eddy, who advised the Commission on various treatment matters:

> Adequate evaluation of all treatment modalities is our greatest lack today . . . There is presently too much rivalry for treatment funds, too little accurate record keeping and too little concern for accomplishment."

Dr. Eddy went on to suggest that:

> It would be nice if every individual group or organization trying to treat and "rehabilitate" drug abusers could be made to register with an evaluating body, made to spell out his procedure and changes which take place in it, made to record epidemiologically every admission and what happens to each one — drug wise, society wise, [and] crime wise as long as contact is maintained.

The Commission is in agreement with the views expresed by Dr. Eddy. He is requesting a colossal undertaking, but one which is vitally necessary if we are to determine which programs are most effective and which are deserving of proportionately larger shares of funding.

Dr. Vincent P. Dole, the "father" of the methadone maintenance form of addiction treatment and an adviser to this Commission, echoed Dr. Eddy's views. He told the Commission that:

> The most important point, in my opinion, is to establish impartial, professionally competent, evaluation of all treatment programs. I believe that any drug program that obtains support from public funds has an obligation to keep accurate statistics on the number of patients admitted to its program and their fate in treatment. What is needed is an impartial and efficient score keeper so that we can learn from experience and become more effective in dealing with the problem.

Dr. Dole went on to recommend the establishment of such an evaluating committee as an important step in providing for a more judicious expenditure of state funds in the area of drug treatment. He suggested that:

> If the Commission were to find a procedure to support professionally competent people in the field and create an evaluation committee for all treatment programs dealing with drug addicts, modeled on the example that has been set by the Evaluation Committee at the School of Public Health in Columbia University, New York City, a real advance would be made in the field. None of the drug free programs at present have such evaluation.

The views of Dr. Eddy and Dr. Dole hold the key to eventually finding the predictably best treatment for the individual drug addict. Currently there are many treatment programs extant in Illinois and the nation. Considerable detail is known about virtually every aspect of the programs except their relative effectiveness. Today it has become a presupposition that the state must provide a broad arsenal of treatment modalities for the rehabilitation of drug addicts and others whose health has been impaired in some way by drugs. Unfortunately, clear evidence of which programs are the most effective or the most feasible is still lacking.

Virtually every modality can point with pride to one or more former addicts who were "cured" by its program. One must always consider, however, the natural phenomenon of "maturing out" whereby addicts cease using drugs through their own inclinations. Thus, any "success factor" must reckon with the possibility that some patients would have grown out of their habits irrespective of the program applied. Dr. Granville W. Larimore told the Commission that:

> In evaluating treatment modalities one must always bear in mind the usual progression of the course of one disease that is manifested by narcotic addiction. If one assembles a group of 100 narcotic addicts in their late teens, for example, one would find that by age 50 there were very few who were still using drugs. Many of them would, of course, be dead since the mortality rate for addicts is extremely high. However, many of them would simply abandon the use of drugs as a reflection of what has been referred to earlier as the maturing-out phenomenon. This will occur in many cases even if nothing is done as a result of the addict's personality slowly developing to the point where his emotional age gradually catches up and his personality has developed and his emotional stability has reached a point where he is able to cope with the ordinary stresses and problems of life without resorting to drugs.

Since we know so little about the pathology of addiction, the best that we can hope

to accomplish by any treatment modality is to hasten the course of the maturing-out process. This makes it difficult to evaluate accurately any of the treatment modalities now available. In general, all of them seem to have some merit particularly with older addicts and none of them seems to have a very high rate of success with many of the young teenage addicts. It must also be borne in mind that many individuals who may be swept up in any addiction control effort may not be true addicts but rather "joy-poppers" or infrequent users who do not have an underlying personality disorder conducive to narcotic addiction and respond rather well to practically any treatment modality that is employed.

The following analyses of the many national and Illinois drug treatment programs contain a summation of the many facts and opinions received by the Commission during the past year. Regrettably, they do not contain accurate statistical evaluations of the relative merits and shortcomings of the individual programs described. As Dr. Eddy intimates, such an assessment must await a future era of infinitely greater commitment of government and society to the cure of drug abuse.

The "British System"

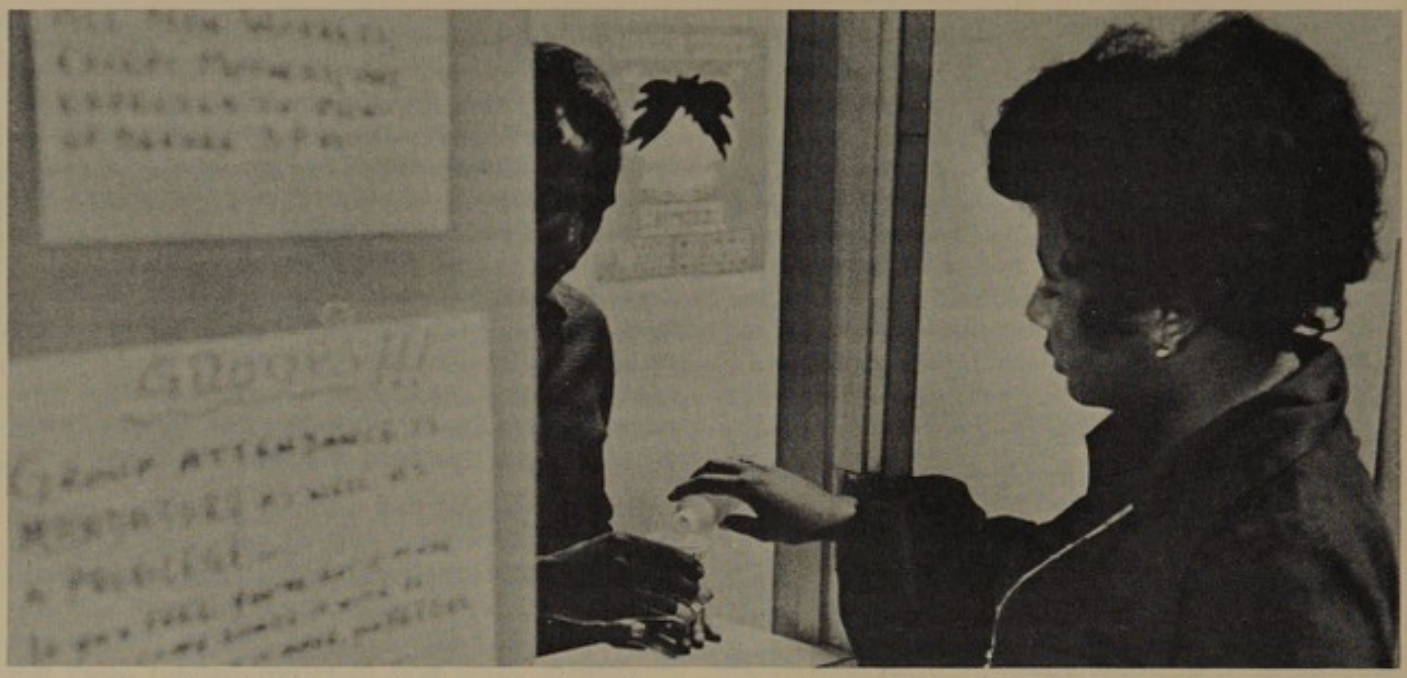
One of the most frequently discussed methods for the control of narcotic addiction, and often the most misconceived, is the so-called "British System". Despite numerous documented reports and accurate journalistic accounts to the contrary, it is the popular but untrue notion in this country that the British have successfully managed to control their addiction problem by freely dispensing heroin and other narcotic drugs to addicts through private physicians and government-operated clinics. We have many well-intentioned but misinformed persons who advocate that a similar procedure be instituted in the United States on the misbelief that it has worked so well in Great Britain. In reality, this has not been Great Britain's experience at all. A review of England's experience is necessary to fully appreciate the situation.

Dr. Henry Brill, an adviser to the New York State Narcotic Control Commission, and his associate, Dr. Granville Larimore, first exploded the myth of the "British System" in 1960. Prior to 1962 there were fewer than 300 known narcotic addicts in Great Britain, where the population exceeded 50 million. The British had taken the position that addiction was properly a medical problem, and therefore private physicians were allowed to prescribe heroin and cocaine to addicts on the premise that this was, in fact, medical treatment. This approach, established in 1926, worked smoothly until the arrival of the tumultous sixties. Soon the abuse of drugs spread rapidly among the young and there arose a corresponding demand for drugs of abuse. The breakdown of the original British approach was marked by the development of the first significant black market for drugs in that country as well as gross overprescribing of narcotics by irresponsible physicians and the proliferation of illegal drugs among great numbers of British citizens.

In the wake of this crisis, the British formalized their approach and moved in a direction similar to that of the United States, where drug abuse control has principally been a law enforcement problem. It is true that the degree of control exercised in Great Britain does not yet approximate that which is current in the United States, but it must be kept in mind that the problem of drug addiction in this country, based on conservative estimates of 250,000 to 300,000 addicts, is several hundred times greater than in Great Britain.

The following extract is from the *Eighteenth Report of the World Health Organization Expert Committee on Drug Dependence.* (WHO) (Wld. Hlth. Org. techn. Rep. Ser., 1970, No. 460, p. 20-22):

> Until recent years the problem of dependence on drugs of the morphine and cocaine types was small in the United Kingdom, less than 300 cases being known to the Home Office up to the end of 1962. The system of controls formerly applied to these drugs, often erroneously called the "British System" and reputedly designed to prevent dependence on them, had been adequate in the absence of a widespread demand for drugs of dependence. However, when — as in other countries — the younger age groups began to seek drugs, the system of controls was shown to be inadequate. Between 1964 and 1967, the number of known heroin and cocaine users increased from less than 500 to about 1500. It was obvious that a new approach to the problem was required.
>
> Based in part on recently enacted legislation, the new "British approach" recognizes the need of the individual for treatment and the need of society to maintain its own health. The principle provisions and goals of this new approach are as follows:
>
> (1) the provision of special treatment facilities within the health service, both outpatient and in-patient, to treat drug-dependent persons;



Former heroin addicts receive methadone in orange juice at the Illinois Drug Abuse Program methadone facility.

(2) the requirement that the patient who desires these drugs attend a clinic fortnightly, weekly, or more frequently if the physician so desires, for treatment and for evaluation of drug dose, thus decreasing the risk of overprescribing and providing a regular physician-patient relationship that might result in motivation to abstinence;

(3) the provision of other services by the central social services and the local authorities;

(4) an attempt to minimize illicit drug-seeking behaviour by supplying the drug legally;

(5) the control of physicians by prohibiting them from prescribing heroin or cocaine to dependent persons unless necessary for the treatment of organic illness;

(6) permission to prescribe heroin or cocaine to dependent persons to be granted only to those physicians who are in receipt of a special license from the Home Office;

(7) the requirement that individuals diagnosed by any physician as dependent on heroin, cocaine, and certain other drugs be notified to the Principal Medical Officer of the Home Office, in order to keep the size of the problem under constant review and to prevent patients attending at more than one clinic; and

(8) to prevent the development of a criminal organization that supplies drugs, measures aimed at reducing the need to seek illegal sources.

It is not possible to understand the rationale of this approach without appreciating the facts that: (a) heroin is used in medical therapeutics is the United Kingdom, and (b) the inquiry revealed no evidence to suggest the presence of a criminal organization involved in the distribution of these drugs, since they were being manufactured and distributed legally and were diverted to drug-dependent persons by patients attending physicians.

Since the introduction of this approach, new cases of heroin dependence have been appearing much less frequently. However, only a small proportion of continuing heroin users have become entirely self-supporting; many seek heroin (which is now scarce) outside the clinics, arrests for both drug-related and other crimes are common, complications arising from the use of unsterile syringes are numerous, and mortality is high. In addition, increasing numbers of persons dependent on methadone are appearing, some of whom have never used heroin. Methadone has not yet been controlled in the same way as heroin. These developments and the substantial amount of multi-drug use have led to the presentation of a new Misuse of Drugs Bill, which would provide additional powers for the control of drugs and physicians. This bill is now before Parliament.

This approach to an acute problem had taken place in a social, medical and national setting that is unlikely to exist in any other country at the present time.

Perhaps the most potentially convincing argument of those who advocate the establishment of the "British System" in this country concerns the interaction of crime, law enforcement, and addiction. In essence, they theorize that the legal distribution of narcotic drugs will destroy the illegal market for these drugs, eliminate drugs as a source of profit for the underworld, and ultimately halt the proliferation of drug abuse. In refutation of this argument, Dr. Frederick B. Glaser and Dr. John C. Ball, writing in the *Journal of the American Medical Association* (May 17, 1971, Vol. 216. No. 7, p. 1178) assert the following:

> It is said that supplying drugs to addicts is desirable because it undercuts any criminal profits and keeps organized crime out of the drug traffic. The British experience is cited as evidence that this is so. This argument is inaccurate in several respects. There has been a heroin black market in Great Britain since at least 1951, and it is more active today than ever before. The massive increase in heroin addiction in Great Britain under the former system is proof of this fact. Although British physicians could formerly maintain already established addicts on heroin, there is evidence that physicians knowingly initiated anyone into heroin addiction. Thus new addicts began in the black market. The principle source of black market heroin in Great Britain has always been overprescribing on the part of physicians, rather than the activity of a criminal syndicate, as is the case in the United States. There is no evidence to implicate large scale organized or syndicated crime in the narcotic black market in Great Britain. This is hardly surprising. Organized or syndicated crime of the type prevalent in the United States does not exist in Great Britain and never has. Therefore its entry into the narcotic market was not a possibility. Moreover, any loss of revenue from drugs which might follow their legalization in the United States would be a relatively minor one to syndicated crime here, as it is so well entrenched in many other areas. Organized crime is a conglomerate and it has many of the protections afforded by that type of corporate structure.
>
> Thus, the basic assumptions of British system theorists have been shown to be erroneous. The British system is a myth.

Dr. Granville W. Larimore, who we mentioned previously, is currently the State Director of the Florida Regional Medical Program. He served as a consultant to this Commission on various treatment matters. As a leading authority on the British System, his strong opposition to its introduction into the United States deserves mention here:

Adoption of a British System in this country would represent nothing short of a disaster. It was my priviledge to make with Dr. Henry Brill three detailed studies of the so-called British System in recent years. The very nature of addiction makes the concept of providing "maintenance" doses of narcotics virtually an administrative impossibility. For example, the factor of addicts maintenance level at the beginning of his entrance can only be guessed at by the physician as can also the increase of dosages necessitated by the tolerance factor. Addicts in general are utterly unreliable as to veracity and can be depended upon to exaggerate their needs for drugs so as to acquire an excess which may be stock-piled or shared or sold to fellow addicts.

A staff member examines a supply of methadone in the North Side Clinic in Chicago, operated by the Illinois Drug Abuse Program.

At the clinics in England where drugs are provided addicts, each encounter between the physician and the addict represents a struggle between the physician seeking to keep the addict's daily drug consumption down and the addict seeking to get more drugs. Physicians in England serving in the narcotics addiction clinics pointed out to us that the whole system would likely collapse if any sizable black market in narcotics drugs should develop in England since any efforts to control dosage would become futile. In view of the liberal supply of illicit drugs ex-

isting in many sections of this country, it is quite evident that if addicts are given too large a supply of drugs they will promptly appear in the black market. (Addicts are a 'feckless lot', the English say, and will sell excess drugs even though they may realize that they will be in need later on). If they are given an insufficient supply they will turn to the black market for additional drugs. In either instance, the basic problem has not been solved or even effectively approached.

Doctors H. A. Abramson, P. A. Carone and L. W. Krinsky of the South Oaks Research Foundation in New York, on the other hand, discern some value in a greatly modified form of the "British System" for the United States:

> The British seem to take the point of view that drug addiction is a disease and, therefore, should be treated by physicians who, in turn, are responsible for the success or failure of their treatment. The view at present in force here seems to be that drug addiction requires the combined efforts of psychologists, social workers, physicians, administrators, etc., who divide the treatment and are not individually responsible for the results. Such team work, theoretically valid, adds greatly to the cost of the program, divides the responsibility, complicates the machinery and provides innumerable opportunities for malfeasance.
>
> It is felt that if a widely distributed fraction of the more than 300,000 physicians in the United States were given special courses on the treatment of drug addiction, they could handle the drug problem more competently and more effectively at a much lower cost.

From the foregoing discussion it seems obvious that to pursue the amorphous "British System" in this country would promise nothing in terms of controlling the addiction problem. In fact, turning over heroin-prescribing abilities to private physicians or government clinics in this country could likely multiply the situation. As it exists today, the "British System" is suited only, if at all, to the particular setting of Great Britain and would probably be singularly inappropriate for the conditions which exist currently in the United States.

Another fact, too infrequently acknowledged in the past, is that in the early 1920's heroin was legally dispensed in government clinics with disastrous results that led eventually to the cessation of this practice. As was the case in England, the heroin addict population increased rather than diminished. In the face of the current and serious escalation of heroin addiction in this country, a repetition of the "dope clinic" experiment would be catastrophic.

Methadone Maintenance

Methadone is a synthetic narcotic drug which was developed during World War II as a substitute for morphine. Its modern application as a form of treatment for heroin and morphine addiction had its genesis in the research conducted by Dr. Vincent Dole and Dr. Marie Nyswander in 1963 at Rockefeller University in New York. Through their studies they discovered that methadone, when administered orally and in appropriate dosages, has the ability to block the effects of any amount of subsequently injected heroin, eliminate the craving for heroin in detoxified addicts, and produce neither euphoria, drowsiness, nor any other distortions of behavior commonly associated with narcotic drugs. They proposed that if heroin addicts were administered oral methadone on a regular basis they could be drawn out of the addict community and made receptive to rehabilitation to a productive social role.

The modern methadone maintenance concept employs the Dole-Nyswander theories. In operation, it consists of administering daily dosages of methadone to heroin addicts, in a form which is not susceptible to injection. The amount administered is determined after the addict has been stabilized at a given dosage level. The methadone programs which have been in operation since the announcement of the Dole-Nyswander theories have proved that this administration of the drug does, in fact, produce certain beneficial effects: subsequently injected heroin has no effect whatsoever as the physiological craving for heroin is eliminated. Since the drug is taken orally, the risk of hepatitis and other infectious diseases from the use of unsterile syringes is eliminated. Lastly, the patient's stablized condition facilitates rehabilitation through psychotherapy and other means.

While at times heralded as a miracle cure for opiate addiction, methadone maintenance, like other forms of treatment, is imperfect. Some of its critics have often questioned whether its detrimental effects outweight its potential benefits. They contend that methadone maintenance is no more than a variation of the previously discussed "British System", and that it cannot be considered genuine therapy because it proposes continued addiction to a narcotic drug. They also caution proponents against admitting young people and people with only brief histories of narcotic addiction to the maintenance programs while there is still a chance that some abstinence form of treatment might still prove effective. Further-

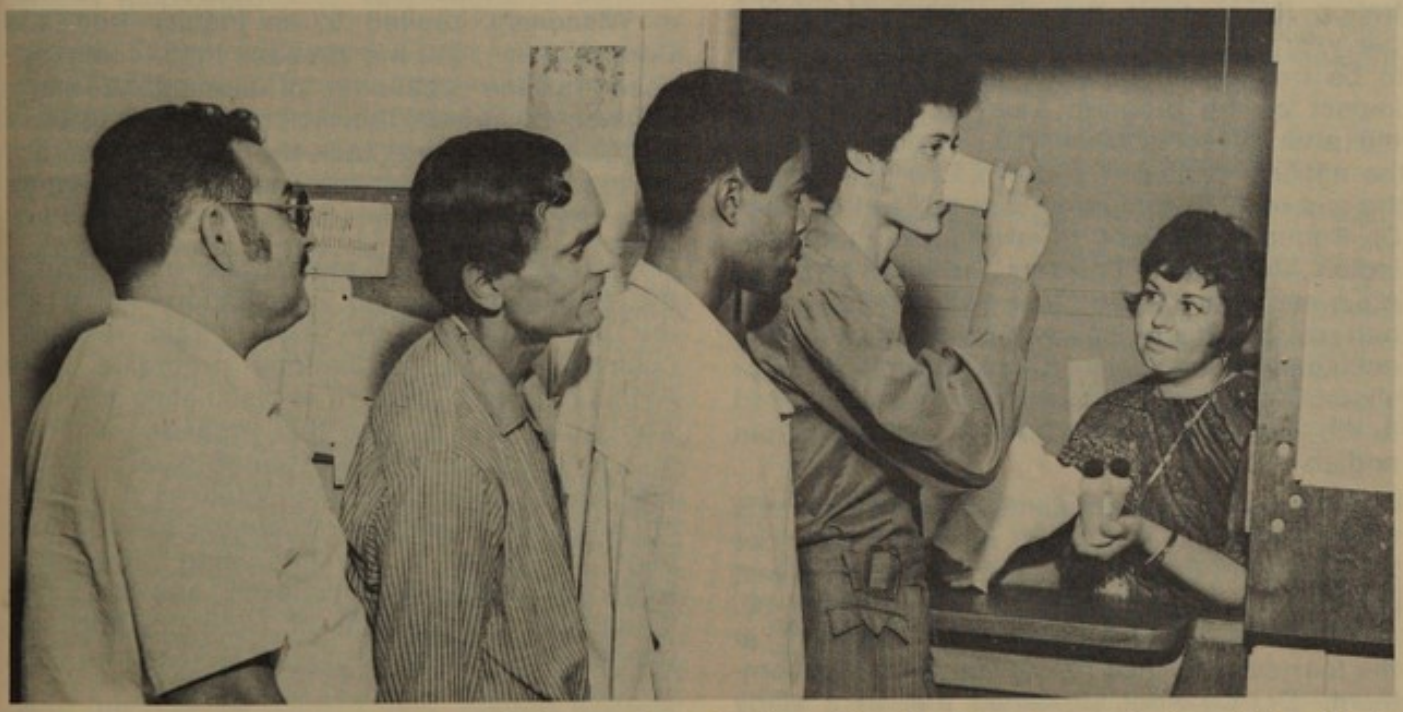
more, since the methadone maintenance concept does not emphasize eventual withdrawal from the drug, it must be expected that program patients will endure lifetimes of addiction to its use, while its long-term consequences are still unknown. They also express concern that the wholesale distribution of methadone could multiply the current drug abuse crisis because when injected, methadone produces effects which are nearly identical to the effects of heroin.

Some black leaders make the further allegation that methadone maintenance is simply a white "colonial" device to keep the Negro passive and enslaved. Of course, this charge is invalid considering the facts that (1) methadone maintenance, when administered carefully, offers the only alternative to a dismal life of addiction for many hard-core addicts and (2) the addict population has gradually shifted in composition so that today more than half the heroin addicts in the United States are white.

The programs envisioned by Drs. Dole and Nyswander are highly structured, comprehensive, and rigidly controlled. Programs of that genre have been established in New York, where the method was pioneered, Illinois and Washington, D. C., to name but a few. The New York program, established at the Bernstein Institute of the Beth Israel Medical Center, now treats over three thousand patients on methadone maintenance. It incorporates a two years. They must be at least 18 years of age, and, as a general rule, have no history of psychoses, severe mental disturbances, or mental deficencies which would disable them from handling the responsibilities which are inherent in the program.

Just as this screening process protects the welfare of the individual patient, security measures against diversion of the drug to the illegal market are necessary to protect the general public. In the New York program, newly adcarefully planned system of patient screening and security against diversion. In addition it offers collateral services which are necessary to accomplish true rehabilitation, such as medical, legal, and vocational services. Patients admitted to the program must be opiate addicts with a period of addiction measuring at least mitted patients are required to report to a clinic daily to receive their dosage of methadone, which is dissolved in fruit juice, and which must be taken in the presence of a nurse.

As treatment progresses, they are required to report to the clinic less often so that eventually they report once per week. During this phase, they are given daily supplies of the drug to take with them for the times when they do not report to the clinic. These supplies are bottled in daily dosage amounts and dissolved in fruit juice to prevent injection. The empty containers must be returned to the clinic



Former heroin addicts receive oral doses of methadone dissolved in orange juice at the North Side Clinic in Chicago.

before the patient may receive subsequent supplies. Each time a patient reports to the clinic he must leave a urine specimen. A urinalysis is conducted to determine if he is taking the daily dose of methadone and if he is taking unauthorized drugs.

The New York Program's experience is probably the best indicator of the effectiveness of the methadone maintenance concept, since it has been operational for the longest period of time. The results of an independent evaluation study indicated the following:

Patients in the program were compared with heroin addicts who had merely undergone detoxification at various governmental facilities. Three years prior to entering methadone maintenance, they averaged 120 arrests per 100 patients per year while the detoxified addicts averaged 131 arrests per 100 patients per year. After four years of participation in the program the same groups were studied. The results showed only 4.5 arrests per 100 methadone patients per year as compared with 134 arrests per 100 patients per year for the detoxified addicts. During the course of methadone treatment, 25 per cent of the patients had jobs upon entering the program, 50 per cent had jobs after six months, 80 per cent after two years, and 92 per cent after three years or more.

On a Federal level, the nation's first large scale methadone maintenance program was established in Washington, D.C. This program, operated by the Narcotics Treatment Administration (NTA) costs the city about $4,000,000 per year and by the end of 1971 is expected to be treating about 4,000 addicts. The chief impact of the program thus far has been in the area of reducing crime. Major crime in the nation's capital was down 22.9 per cent at the end of 1970 compared with the end of 1969. Dr. Robert L. Du Pont, in referring to the Washington Methadone Program, recently told the American Psychiatric Association that while part of this decrease resulted from a virtual doubling of the city's police force, "a major share of this accomplishment was attributed to the treatment of thousands of chronic heroin addicts."

There are an estimated 16,800 heroin addicts in the District of Columbia, representing about 22 per cent of the capital's population. The vast preponderance are black, male, and under 30. About 2,700 are currently under treatment at the fourteen facilities run by the district government. Dr. Du Pont explained that in a study of 475 NTA patients over a six month period, the methadone maintenance approach has proven incomparably more effective than abstinence. Further, "86% [of the methadone patients] stayed with the program during the six month stay, where only 15% [of the abstinent patients] lasted six months." In our own state, the Illinois Drug Abuse Program of the Department of Mental Health has incorporated methadone maintenance as an integral part of its multi-modality approach to narcotic addiction. Currently, the Drug Abuse Program treats over 1,500 drug abusers. Approximately 80 per cent of these are undergoing some form of methadone maintenance. Dr. Jerome H. Jaffe, former Director of the Drug Abuse Program, estimated that the methadone program saves the citizens of Illinois an estimated $30,000,000 per year in crimes that might have been committed by former heroin addicts. A more detailed description of the Illinois Drug Abuse Program is provided in this chapter.

As mentioned above, the Dole-Nyswander concept requires strict adherence to highly structured and rigidly controlled standards. Many of the fears of the critics of methadone maintenance have been realized through poorly conceived variations of this original plan. Basically, these variations have been programs or practices administered by private physicians who have neither the ability nor the resources to provide patient screening, security, or collateral services. This opinion is shared by many noted authorities in the field of addiction treatment. Dr. Richard I. H. Wang, Professor of Clinical Pharmacology in the Medical College of Wisconsin, replied to an inquiry from the Commission: "At the present time, I am opposed to the institution of methadone maintenance by private physicians in their private offices because they lack the controls that are necessary to prevent methadone maintenance from being abused."

In a statement on methadone maintenance the American Medical Association called for the application of the most "rigid research controls" to the methadone programs. The AMA Committee said: "It is disquieting to those who would like to see this program continue at a properly controlled research level to know that it has since been presented as if it were an established, effective treatment method that might be taught to any interested physician." [AMA Committee on Alcoholism and Drug Dependence, Management of Narcotic-Drug Dependence by High Dosage Methadone HCL Technique, 201 J.A.M.A. 956 (1967).]

Taking an opposing view are Doctors H. A. Abramson, P. S. Carone, and L. W. Krinsky

of the South Oaks Research Foundation in New York. In a report written for the Commission they state the following opinion:

> The increase in the rate of crime goes unchallenged. Is it possible that the FDA has unwittingly contributed to this increase? When a drug addict is unable to obtain help from a physician he will seek help elsewhere and, over the past ten years, that help has been derived from the illegal purchase of opiates.
>
> The effectiveness of methadone maintenance programs conducted under treatment facilities has been hampered by their being top heavy, complicated to administer, and burdened by bureaucratic processes.
>
> The private physician, wishing to use methadone in the treatment of heroin addicts, must have an IND number from the FDA and agree to follow FDA rules strictly and precisely unless special exemptions are specifically made for a given case. Since many physicians strongly object to having the decision for what is best for the patient taken away from them (while the responsibility for results remains solely theirs), the use of methadone by private physicians has been negligible.
>
> It should be noted that methadone maintenance programs require a daily visit by the addict and, according to a report by a New York City committee assigned to study the subject, seem to be most effective when the patient is ambulatory, goal-oriented, and usefully employed.

In the future much more will be learned about the effectiveness of methadone maintenance as a form of treatment for narcotic addiction. Serious research is currently being undertaken in an effort to analyze more accurately, and perhaps improve, this approach to the drug problem. Much of this research is occurring in Illinois. Dr. Jaffe, writing in the *Journal of the American Medical Association* with Dr. Edward C. Senay, recently announced the results of preliminary studies with a similar synthetic called 1-methadyl acetate, commonly referred to as "methadol." They reported that methadol has qualities similar to methadone but offers a significant improvement in that its effects last twice as long. In practical terms, this improvement would mean that patients might have to take dosages of the drug only two or three times a week, rather than daily. This would allow the accommodation of many additional patients, who are now on waiting lists, without increasing the number of staff personnel in the maintenance programs.

In its *Eighteenth Report,* the World Health Organization Expert Committee on Drug Dependence made the following observations:

> Among [the aspects of the program which have been clearly established] are:
>
> (1) The degree of tolerance and cross tolerance [sufficient to blunt or suppress the acute effects of drugs of the morphine type] can be established and maintained without overt evidence of adverse effects.
>
> (2) Some, but not all, persons with drug dependence of morphine-type will accept the regimen of methadone maintenance and will apparently desist from much or all criminal activity and attain a more acceptable degree of social and vocational adjustment.
>
> Among the points on which there is not sufficient evidence and on which further research is urgently needed are:
>
> (1) The characteristics of persons with drug dependence of morphine type who will accept and continue in various types of programme utilizing different forms of methadone maintenance. The extent to which such factors as age, current social status, duration of dependence, and multiple drug-use are significant factors.
>
> (2) The basic criteria for admission to the programme.
>
> (3) The tendency to continue with the drug of dependence or turn to other drugs, the effects of which are not interfered with by methadone.
>
> (4) The extent of antisocial behavior and/or criminal activity while on methadone maintenance.
>
> (5) Optimal methadone dosage for various patients in different programmes.
>
> (6) Alternative agents that might be used.
>
> (7) Reliability of data collected.
>
> (8) The degree to which various elements in methadone maintenance programmes (for example, methadone itself, counseling, professional and peer-group support, social services, group therapy) contribute to the treatment outcome.
>
> (9) Whether rehabilitation can be attained to a degree that will permit cessation of methadone administration. If so, in what circumstances? Alternatively, is methadone maintenance, once established, a permanent way of life for social adaptation?

Dr. Larimore expressed measured optimism over the advisability of widespread adoption of methadone maintenance:

Heroin addicts at a Chicago area facility take part in a group therapy session.

Methadone maintenance programs are, in general, more effective and satisfactory if administered by formal treatment facilities than by private physicians. Formal treatment facilities are more apt to be able to provide the necessary controls and essential follow up than can a private physician.

Further, it could be expected that any treatment facility employing a methadone maintenance technique should also provide such supportive measures as psychological and psychiatric therapy where indicated and vocational training and other rehabilitation measures aimed at making the drug addict a contributing member of society. If the private physician can provide suitable control and adequate supportive services there is no reason why maintenance programs could not be carried out under his aegis.

By way of caution, it should be noted that while methadone maintenance programs have a role in an overall narcotic addiction control program, they are by no means the total answer and methadone maintenance is not a satisfactory treatment modality for a significant proportion of addicts who among other deficiencies may lack the motivation to participate in such a program. Particularly is this true of the young hedonistic type of addict.

In summation, methadone maintenance now appears to be the most practical treatment approach yet devised for the social rehabilitation of most heroin addicts. In a properly administered program these addicts may be given the opportunity to rejoin society as productive members. Although still addicts they no longer seek euphoric escape from reality. The comparison is often drawn between maintaining an addict on methadone and maintaining a diabetic on insulin: until a "cure" is discovered, alleviating the symptoms of a disease is often the only reasonable alternative.

A comparable treatment approach to methadone maintenance has been the development of a series of drugs known as narcotic antagonists. They differ from methadone in that they are not synthetic opiates and they do not act as a substitute for narcotics.

These are drugs that occupy the sites on the nerve cell ordinarily occupied by heroin. If these sites can be successfully blockaded by safe agents, the heroin "high" can be blocked. Nalorphine, cyclazocine, and pentazocine are already in use, but they suffer the disadvantage of being relatively short acting, and they produce some side effects in some addicts.

Considerable research is underway in the study of how opiates interact with nerve cells. The precise nature of the narcotic binding site is being studied intensively. The more that is learned about this phenomenon, the better the chances of finding an optimal chemical deterrent.

Research is being conducted to develop an implantable device combining polymer plastic

and a morphine antagonist in order to permit slow release of the antagonist over an extended period of time. Such devices would greatly extend the effective duration of cyclazocine and other antagonists and make repeated medication less necessary in the treatment of addicts.

Perfection of the narcotic antagonists would represent an important addition to the arsenal of present treatment methods. There are several authorities who have stated that the antagonists may become the most effective form of clinical therapy yet devised in the treatment of narcotic addiction.

In addition, a methadone disc has been developed which melts into a "sludge" too viscous to be drawn into a syringe. This form of administration will obviate the possibility that now exists for addicts to boil off or otherwise separate the fruit juice from the methadone and inject themselves with the residue.

Therapeutic Communities

Next to methadone maintenance the method of treatment for narcotic addiction and drug abuse which has received the most popular attention and notoriety is that of the "therapeutic community." In the past this technique has been employed for psychiatric treatment in many different contexts, including schools and universities and penal and other settings where attempts are made to alter unacceptable behavior patterns. Today, it has been adapted for use as a drug treatment method. It began in 1958 upon the founding of the "Synanon" organization in California. Since then, similar programs have been established in New York, Chicago and many other cities. Therapeutic communities differ from the Synanon concept. However, in that Synanon members never leave the community; whereas most therapeutic community graduates return to "straight" society.

Chicago's Gateway House, one of the first and most effective drug treatment centers, operates on the basic principles of rehabilitation through abstinence and group therapy.

The basic premise upon which these programs are based is that the abuse of drugs is but a symptom of an underlying character disorder or emotional immaturity. Consequently, their main objective is to evoke a major restructuring of character.

In a typical community, all the members live together in a single residential facility and perform all their requisite housekeeping functions. Total abstinence from drugs is required and physical violence is not tolerated. The purpose of the community is to develop responsibility to one's self and to the community in general, through a combination of group therapy, controlled environment, and reinforcement of positive behavior changes.

Incoming members admit, and it is assumed by the other members, that they have been behaving immaturely and irresponsibly, as evidenced by their abuse of drugs. They commence with the most menial of tasks, which they are expected to perform well and cheerfully. During this initial phase they are granted only the most meager privileges and are relegated generally to the lowest positions of status and responsibility. Often they must sleep on floors and in groups at the outset. As their attitude and control improves, they are graduated to more comfortable sleeping quarters with increased privacy. As they develop emotionally and demonstrate positive behavioral changes, they are promoted to more responsible positions and are granted more liberties such as spending money, cigarettes and TV privileges.

Most communities have also evolved techniques, including expulsion from the community, for punishing undesirable behavior. For a good example of these techniques, see the section of this chapter dealing with the Gateway Houses of the Illinois Drug Abuse Program.

A special form of group interaction is obligatory, where there must be a willingness to be direct and to expose each member's attitudes and unacceptable behavior to probing, harsh, and verbally aggressive attack. At the same time, there is a tenderness and concern for the

participants that would be difficult to duplicate outside a residential situation.

There are many variations in the applications of these techniques and in the size and physical surroundings of each community. The staff—administrative, maintenance, and clinical — includes former drug users who have themselves passed through such a community. Some programs provide professional personnel, such as psychiatrists, physicians, psychologists and social workers; in others the staff is firmly anti-professional, denying the possibility that anyone who has not used drugs can have insight into the problem or play any role in helping drug users.

According to the WHO Expert Committee on Drug Dependence:

> It has become clear that most such communities in the USA have only a limited appeal. It is estimated that about two-thirds of those who make contact (in themselves a small, self-selected group) with the communities become residents and of these probably only one-half to one-third remain residents for more than a few months, the rest leaving without the approval of the community. Whether or not those who leave revert to drug use is unknown, but it is generally assumed that they do. If long-term improvement does occur, it is probably limited to less than one-third of those who make an initial contact with such communities.
>
> Whether character-change is produced in such communities is not known. In any case, other methods of treatment of character disorders do not claim high rates of change. Most of the former drug-dependent "graduates" have become staff members of their parent organizations or some other organization utilizing similar procedures. Although pharmacological approaches to morphine-type dependence [e.g., methadone maintenance] may offer useful alternatives to these programmes, the same cannot be said for drug dependence of the barbiturate and amphetamine types. Furthermore, even if the sole benefit of such communities is the provision of an environment in which the participants can function, the benefit to society is great in that most of these persons are no longer involved in illegal drug use or in criminal and other untoward behavior. These programmes also demonstrate that some former drug-users can live together in an orderly and structured society.

Dr. Larimore feels that therapeutic communities occupy a necessary place in the state's arsenal of treatment modalities. In his view:

Therapeutic communities have shown themselves to be a useful adjunct to an overall narcotics addiction control effort. They are not, however, suitable for all addicts and there is a sizable percentage of failures which is often not metioned or is minimized by the advocates of this modality.

Therapeutic communities are also expensive in real terms although this factor tends to be overlooked since their direct costs are sometimes minimal because of volunteered services, food and shelter. It must be remembered, however, that these services must come from the community at someone's expense; that is, in reality they are not free.

Therapeutic communities do seem to have a role, however, in hastening the maturing-out process and in general appear to work better with the older addicts. This may simply reflect the fact that such methods are best able to aid those who are close to the point of remaining off of drugs as a result of the maturing-out phenomenon. This same maturing-out phenomenon may be an influencing factor on methadone maintenance programs as well. The early successes of the methadone programs were in the main with older addicts, older that is in terms of drug usage.

Doctors Abramson, Carone and Krinsky are not enthusiastic about the prospects for success with therapeutic communities on a large scale:

> The cost of organizing a therapeutic community may restrict this approach to the treatment of small numbers of addicts, or those addicts who can afford long-term, drug-free psychotherapy. Morever, only a small percentage of addicts are motivated for such a program. Statistics indicate a very sizable percentage leave residential communities the very first day.

In summation, the major criticisms of the therapeutic community appear to be the following: (1) successes have primarily been with well-motivated persons who have been addicted for relatively short periods; (2) the duration of treatment is very long, usually 18 months to two years; (3) the dropout rate is commonly very high, often 80 to 85 per cent of those who begin the programs; (4) some guests a re inclined to remain indefinitely and are reluctant to return to an integrated outside community; (5) the cost per guest for extended residence therapy is much greater than for alternative approaches, e.g., methadone treatment, since larger staffs and more physical assets are required.

However, as the WHO report suggests, the therapeutic community may be the most effective method of treatment for some drug abusers, especially those dependent on non-

narcotic drugs. The conclusion to be drawn from this is that there is a definite need for the availability of many forms of treatment, as provided in the "multi-modality" concept of the Illinois Drug Abuse Program.

Civil Commitment

Although not a form of drug-abuse treatment per se, the civil commitment of narcotic addicts is so closely related to the various forms of treatment that a discussion of its merits is warranted in this chapter. Under the concept of civil commitment, persons who are addicted to narcotic or dangerous drugs may be placed in a treatment facility, involuntarily, by a court order obtained on the petition of third parties, whether or not there is any criminal charge pending against such persons.

This concept is not new. Prior to 1962, thirty-two states had some form of civil commitment provisions for addicts. However, they were rarely, if ever, used because of a lack of adequate treatment facilities. In most cases, commitment was to ordinary mental health facilities where addicts were typically placed in isolation, given little or no treatment, and discharged by hospital administrators who found them difficult to handle in a standard institutional setting, and a disturbing influence generally.

Dr. Larimore supports the concept of civil commitment as a last resort for hard core addicts. He told the Commission that:

> There is merit to a civil commitment procedure such as that in New York and California whereby persons who are addicts may be involuntarily held for treatment without a pending criminal charge. Such a commitment procedure recognizes among other factors that the narcotic addict has been in almost every instance a law breaker in order to provide the funds needed to support his habit. This is simply a fact of life with respect to most narcotic addicts. Further, it must be borne in mind that many narcotic addicts have other antisocial tendencies, some of which existed prior to becoming addicted to drugs.
>
> The British physicians dealing with the problem make a considerable point of this fact noting that most addicts have had episodes of antisocial behavior that brought them in to contact with the law even before they became addicted to drugs. Thus the narcotic addiction is often yet another symptom of an underlying personality disorder which is reflected in antisocial behavior both before and during addiction.

In Illinois there has been a statutory provision since 1957, Ill. Rev. Stat. ch. 23, § 3501 *et seq.* (1969).

This statute, included in the chapter entitled "Charities and Public Welfare," provides for the compulsory civil commitment of persons addicted to narcotic or dangerous drugs upon the petition of the addict himself or the petition of "any reputable citizen."

A court order under this statute makes the addict a ward of the Director of Law Enforcement. Such order remains in effect until the addict has recovered and is released. The Director of Law Enforcement may place the addict in the care of any of a number of appropriate state treatment facilities.

As was the experience in other states, this statute is seldom used. In reply to an inquiry by the Commission, Mr. Herbert D. Brown, Director of Law Enforcement, made the following reply:

> The statistics of the former Division of Narcotic Control show that a total of one hundred and twenty persons were made wards of the Superintendent of the Division since enactment of the Civil Commitment Act, Chapter 23, Section 3501. Most addicts who voluntarily submitted themselves for detoxification were assigned to facilities at the Tinley Park Mental Health Zone Center. Since it was a voluntary program, they were released shortly after detoxification.
>
> Those addicts charged with the misdemeanor of being addicted to a narcotic drug were sentenced to a period of three months confinement for detoxification at either of the U. S. Public Health Service Hospitals at Lexington, Kentucky, or Fort Worth, Texas.
>
> When civilly committed addicts were released on probation from confinement for detoxification, they were subjected to the Nalline Testing Program which was conducted at the Rehabilitation Center located at the Chicago office of the former Division of Narcotic Control. This program proved successful because probationers were given only a 24 hour notice to appear for this test. If a probationer had taken any opiates within the preceding 72 hours, the test would be positive. Under this program, the probationer was required to take Nalline tests at frequent intervals. Therefore, recidivism could be detected.
>
> Since the start of the Illinois Drug Abuse Program in 1968, all persons requesting treatment and rehabilitation for addiction have been referred to the director of that program. . . Currently there are no persons who are wards of this department. Records

A basic concept of the Gateway House is that drug dependent persons are somehow immature and irresponsible individuals who are unable to practice the necessary self-control needed to avoid drug abuse. Counseling sessions are held frequently to help the resident realize his inherent personality defect.

showing the disposition of those persons who were wards of the Division of Narcotic Control are not available from this department.

Since 1962, a new generation of programs for the civil commitment of addicts has been established by the federal government and the States of California, New York, and Massachusetts. Features common to all four programs include the following: addicts not charged with the commission of a crime may be involuntarily incarcerated for prolonged periods of time; during that time they must be sent to highly specialized narcotic treatment centers where they are withdrawn from their physical dependence on narcotics and receive therapy for their psychological dependence; there is a maximum term of commitment provided, but a person may easily be re-committed if he relapses into drug use after he has been released.

These new programs, which now treat hundreds of patients, have been severely criticized from their inception. From a legal standpoint, many authorities believe that the entire civil commitment concept is unconstitutional and should be stricken by the courts. Writing in the March, 1967 issue of the *Columbia Law Review,* Mr. Dennis S. Aronowitz, Assistant Professor of Law at Washington University (St. Louis) comments that, "Involuntary civil commitment of non-criminal narcotic addicts is not justified on the basis of existing knowledge about addicts, addiction or methods of treatment, and that such programs represent an unreasonable and improper deprivation of liberty". Various law review commentators have concluded, for example, that "if they are applied as written, the New York and California addict-commitment programs are almost certainly unconstitutional." (NOTE: Civil Commitment of Narcotic Addicts, 76 Yale L.J. 1160, 1189 (1967).

In general, these objections are based on the following arguments: The state has the power to civilly commit non-criminals, if at all, on the bases of *parens patriae,* or its police power. Justification for commitment must be able to stand entirely on one or the other. The state cannot fuse an inadequate police power justification and an inappropriate exercise of paternalism into a jointly sufficient basis for commitment. When the state seeks to incarcerate under the principles of *parens patriae,* it has traditionally done so in cases where an individual is incompetent to decide for himself whether to undergo treatment, i.e., in matters concerning infants, idiots and imbeciles. Insanity per se is not sufficient, nor is a mental condition or defect which causes eccentric or irrational behavior of only a particular type. In this context, it is asserted that drug addicts, although incapable of deciding for themselves to stop using drugs, may be perfectly capable of deciding whether or not to attempt a cure. Given the facts that many addicts would prefer to face the world with a crutch rather than endure reality, and that most institutional drug rehabilitation programs have been notorious failures, the decision to remain an addict may not always be an irrational one. In consequence, it is argued that the state has no right to impose its decision on some large percentage of addicts.

It has also been contended that on the other hand, when the state seeks to incarcerate a non-criminal under its police power, i.e., for "preventive detention," it has traditionally done so in instances where there is an immediate and probable danger to its inhabitants. In an anlagous situation, the usual requirement for mental health commitments is a judicial or administrative finding that the individual to be committed is dangerous to the person of others or himself, or to property — although in a few states and the District of Columbia commitment is limited to cases of danger to persons alone. The standard of danger warranting commitment varies somewhat, but the prevailing view is that the danger must be reasonably probable and immediate, not merely possible or conjectural. In other words, commitment

must be based upon a specific finding that there is a substantial likelihood the person to be committed will, rather than *may,* commit dangerous acts. In addition, in no case has a state attempted to incarcerate an individual, absent proof of mental defect or deficiency, on the ground that he poses a threat to society because of his criminal propensities. For example, a state cannot continue to imprison a person after he has served his sentence for a crime, even though he may be just as dangerous as the day he was imprisoned. With regard to narcotic addicts, then, it is alleged that there is no evidence that all, or even a substantial percentage, are more inclined to commit crimes of violence than the average person (e.g., the addicted doctors and pharmacists who have access to an inexpensive and ready supply of drugs). Thus, if the civil commitment statutes are applied to addicts *sui generis,* there is a denial of due process for many non-dangerous individuals.

The final major legal objection to the civil commitment statutes is that they attempt to circumvent the ruling of the United States Supreme Court in *Robinson v. California,* 370 U.S. 660 (1962). This case held that it is unconstitutional to punish an addict because of his status as such. Although the Court also said in dicta, that it would be permissable to compel addicts to undergo treatment, the critics charge that in too many cases the commitment procedure is quasi-criminal and offers little or no treatment for addiction. In many "treatment" facilities the atmosphere is clearly penal in nature. Therapeutic endeavors such as psychiatric counseling are exceedingly rare. Thus it is argued that commitment to institutions which are *de facto* prisons is an unconstitutional evasion of the *Robinson* decision.

From the medical standpoint, many authorities have similarly been unenthusiastic about the civil commitment concept. The general consensus is that unless there is some other pressure, e.g., a pending criminal charge, committed addicts will be poorly motivated, possibly hostile, and will present security problems which most treatment institutions are not equipped to handle. The WHO report made this observation: "The committee considered that the clinical evidence was not sufficient either to support or refute the case for various forms of compulsory treatment, but noted that, in spite of considerable experience, compulsory detention alone has not been shown to be beneficial".

Dr. I. H. Wang, Professor of Clinical Pharmacology at the Medical College of Wisconsin, remarked: "Civil commitment could play a role in the treatment of the drug abuser and the narcotic addicts, but it would be a device only to gain time to convince the person that they need treatment. If the person cannot be convinced in a short period of evaluation and assessment, say fifteen days, further involuntary commitment will serve no useful purpose."

Dr. Alfred R. Lindesmith, of the Sociology Department at Indiana University, has said the following: "The civil commitment programs of New York and California are generally conceded to have been failures. Persons held involuntarily feel they are being punished. Also, how 'treat' them when they are locked up? This program consists mainly of substituting new words for old ones without changing the practices".

In response to an inquiry by the Commission, Dr. John C. Ball and Dr. Frederick B. Glaser of Temple University replied as follows:

> Civil commitment procedures may be summarily dealt with. First there is no evidence that they work. Second, they have so many difficulties from a legal viewpoint that they seem quite out of the question. In order for civil commitment to be workable, the state must show that it has sufficient facilities to handle addicts therapeutically, and few if any states have this. Therefore, addicts can leave treatment through a writ of *habeas corpus,* even after they are committed, and this has happened, for example, in New York. Even if the state did have sufficient facilities, the current emphasis upon civil liberties would make it very likely that any such procedure would be struck down. It seems that the notion of civil commitment is losing ground even in the case of the frankly psychotic individual. In our state [Pennsylvania] for example, such persons must now go through a lengthy and public trial before commitment, and can no longer be committed at the discretion of medical authorities. However one may feel about this, it does appear to be the shape of things to come; and any argument which would apply to the mentally ill would apply more stringently to the addict. Viewed in this light, civil commitment seems an unusually unprofitable avenue of endeavor.

Finally, Dr. Richard H. Blum, Program Director of the Institute of Policy Analysis at Stanford University made the following observation in response to a Commission inquiry:

> Regarding civil commitments we do have them in California as you point out. I am not qualified to address the issue of civil

rights which I am sure you will attend to. My recollection is that the failure rate for these commitments over several years of follow-up is at least two thirds. Perhaps the argument should be that civil commitment is hardly worth the trouble unless we can be sure that the treatment facility works better than the ones we now have in Lexington, Kentucky, Corona, California, and so forth. On the other hand, we must not rule out involuntary treatment because the evidence from alcoholism studies, contrary to much psychiatric experience with other populations, suggest that involuntary treatment can be effective if it really fits the patient.

In conclusion, it appears that substantial rethinking is necessary in the area of civil commitment both from a legal and medical standpoint. This is particularly true in the case of Illinois. Our state's applicable statute has seldom been used since its inception in 1957. It is quite possible that it has never been tested in a truly adversary proceeding since all recorded commitments have been voluntary. There have been no Illinois civil commitments since 1968. Consequently, this statute represents virtually dead law. Were it to be resurrected and tested on appeal, it would most probably be declared unconstitutional. A cursory examination of the act reveals that there is no limiting language for the time between an addict's apprehension and his hearing before a judge. Furthermore, there is no requirement that the alleged addict be informed of his rights to counsel, to remain silent, to demand a trial by jury, to cross-examine witnesses, or to have an explanation of the consequences of a judicial determination that he is, in fact, an addict. Lastly, the Illinois statute provides no maximum period of confinement and creates no standards for what constitutes "treatment."

For these reasons the Commission has concluded that the Illinois Civil Commitment Statute should be repealed. Upon the establishment of commitment facilities which are, in fact, *treatment* institutions, a new statute should be enacted which contains the many constitutional procedural requirements recognized during the past decade.

The Religious Approach

Ancillary to the aforementioned treatment approaches, which may properly be described as "institutional" methods, are the efforts of religiously motivated persons and groups who attempt to dissuade persons from abusing drugs by appealing to their spiritual or mystic moral attitudes.

What has made this approach as successful as it has been is a phenomenon which has developed concurrently within the drug revolution, i.e., an era of swift cultural change wherein many young people are propelled from one enthusiasm to another in a search for relevance, meaning, and stability. In recent years, this has been made manifest by youth's resurgent, and often exaggerated interest in Zen and transcendental meditation, astrology, spiritualism, black magic and the occult, scientology, Krisha's cosmic consciousness, and, in keeping with the pendular tendencies of social attitudes, a revival of Christian idealism in the form of the "Jesus People".

At first, drugs became an integral part of the youthful spiritualistic culture. In the contemporary rhetoric, the psychedelic proselytizers have advocated that drugs are "mind-expanding" and allow deep and serious insights into the mystical unknown. Adding credence to this assertion was the publicity attending the life styles of contemporary heroes, especially rock stars, who were known to use drugs in conjunction with their musical performances and in their own search for relevance. A well known example is the association between the Beatles and a famous Maharishi of India.

Ironically, the current trend among the resurgent spiritualists is to stress near-puritanical temperance with regard to their bodies and their minds. Many of the mystic leaders, who had previously been silent on the issue of drugs, or had actually advocated them, have advised their followers that drugs create an artificial, chemical "consciousness" and are not, in fact, a shortcut to the realization of God. Particularly influential in this area have been the statements of the late Avatar Meher Baba, a spiritual master who formerly lived in California. He was belived to be God in human form by his followers. Responding to letters from one of the foremost psychedelic advocates in America, Baba wrote that "the [drug] experience is as far removed from reality as is a mirage from water. No matter how much one pursues the mirage, one will never reach water, and the search for God through drugs must end in disillusionment". On another occasion, he said: "In an age when individual liberty is prized above all achievements, the fast-increasing number of drug addicts form an appalling choice of self-sought bondage! Even as these drugs hold out an invitation to a fleeting sense of ecstasy, freedom or escape, they enclose the individual in greater binding. LSD, a highly potent 'mind-changing' drug differing from the opium deriva-

Mutual confrontation and criticism are essential parts of the sometimes heated confrontations which characterize the therapeutic community approach to drug rehabilitation.

tives and being used in the research of mental science, is said to 'expand consciousness and alter one's personality for the better!' In America it has become tragically popular among the young, used indiscriminately by any and many. They must be persuaded to desist from taking drugs, for they are harmful—physically, mentally and spiritually."

On another front, groups of young people have taken to membership in evangelistic communes and cadres which collectively make up a movement called the "Jesus People". In a renaissance of Christian spirituality, these groups have turned to the teachings of Christ for direction, relevance and, as one has described, the "ultimate trip." The rolls of the Jesus People include thousands of former drug addicts, would-be revolutionaries and other dropouts from the counterculture. The Jesus People scrupulously avoid the use of drugs, and carry this strict observance of the law into all their daily activities, even including the avoidance of traffic tickets. Exactly how great an impact the religious groups will have on the drug problem cannot be predicted at this time: however, it is known that many thousands of interested young people attend the various events sponsored by these groups throughout the country, and their publications reach a sizeable audience. It would be wise to carefully watch developments and trends in this area because it may offer an insight into the nature of the drug abusers in particular.

A number of programs of a more organized nature such as "Teen Challenge" have combined drug therapy with an evangelistic spirit of reform. These programs have generally been more successful with persons of a Protestant heritage—particularly those of an Adventist persuasion. In many large cities, particularly Los Angeles, many of these modern-day Christian zealots have been termed "Jesus Freaks" — the implication being that they are "freaking out" on God rather than drugs.

Services Available in Illinois

1. *Introduction.* Illinois, being one of the most populous states, has one of the largest addict populations as well. The history of addiction in Illinois probably can be traced as far back as the presence to white civilization within our borders. Certainly our state has not escaped the impact of the current drug revolution. As might be expected Illinois has invited a wide variety of treatment and rehabilitation services. Some of these have been well-conceived and have met with noteworthy success; others have failed. The remainder of this chapter will deal with those services available to

drug abusers in the state. In preparation for this section the Commission contacted a number of agencies which list and catalogue such services; however, we are advised that these represent only the larger sources of treatment and rehabilitation services. There are undoubtedly many others which address themselves to the drug problem but have chosen not to publicize their efforts.

2. *The Illinois Drug Abuse Program.* The Illinois Drug Abuse Program is the official State response to drug abuse prevention and rehabilitation demands in the State of Illinois. It is headquartered at the Museum of Science and Industry, East Pavilion, 5700 South Lake Shore Drive, Chicago, Illinois 60637. It was planned over a two-year period, beginning in 1966 when narcotics and other dangerous drugs began to be abused with alarming frequency. At that time, treatment resources in Illinois were scarce and there was little knowledge in the areas of creating and administering an effective state-wide drug abuse program. To fill these gaps and to formulate long-range plans, the Illinois Legislature established the Narcotics Advisory Council, composed of legislators, concerned citizens, and members of various city and state agencies whose functions touched on the durg abuse problem. The task of the Council was to study the problem, consider programs being developed in other states, and make recommendations to the State Legislature. The Chairman of the Council, Dr. Harold Visotsky, sought advice from Dr. Daniel X. Freedman, Chairman of the Department of Psychiatry at the University of Chicago. Dr. Freedman recruited Dr. Jerome H. Jaffe, who joined the Psychiatry Department and served as Chief Consultant to the Council.

By 1967, the Council had reached the following conclusions:

(1). Narcotics abuse was only one part of the general drug abuse problem, and, from a social standpoint, perhaps not the most significant part. However, due to the social conditions surrounding the use of narcotics and the high degree of damaging effects following from narcotics use, it would be appropriate for Illinois to begin with a treatment program focusing primarily on narcotics users.

(2). Since those who comprised the narcotics-using population had different reasons for beginning drug abuse, presented different patterns of abuse, relapsed into drug abuse after treatment for different reasons, and had widely different experiences as results of their narcotics-using behavior, it would be reasonable to expect that more than one treatment and rehabilitative method might be required.

(3). Since there was then no reliable way to predict what types of narcotics users would respond best to what methods, it would be necessary to carry out research to determine which of the methods would be most helpful to the citizens of Illinois.

(4). Goals had to be clearly stated before any meaningful conclusions could be drawn concerning the efficacy of the various methods. Ideally, every method should attempt to help all compulsive narcotics users become law-abiding, productive, drug-free, and emotionally mature members of society who require no additional medical or social support to maintain this ideal status. Realistically, however, the Council recognized that no program at that time could expect to achieve a high degree of success when measured against ideal standards. Consequently, it proposed that as a minimum, a state-wide program should accomplish the transformation of addicts into law-abiding citizens, even if they are not entirely productive, drug-free, or emotionally mature. As the program developed and gained knowledge and experience, it might gradually increase its expectations of success.

(5). Since the proposed program would be operating on public funds, an evaluation system must be implemented to allow an accounting for the net results of these expenditures. Closely related to this was the belief that a large program for any given community should be built on the basis of objective data from a smaller program, and that any program component which did not achieve substantial progress toward the described goals should be abandoned.

As a result of these conclusions, the Council recommended to the Legislature that a singly administered pilot program be established, designed to eliminate duplication of effort, to facilitate patient movement, and to permit uniform evaluation. Initially, the program would focus on a limited geographical area in Chicago which had experienced a high incidence of narcotics abuse. The program would develop, use, and carefully evaluate several different treatment methods which would consist, as a minimum, of the following:

(1). Standard periods of hospitalization for withdrawal from narcotics followed by group

therapy in the out-patient community. Patients would be able to volunteer for the use of cyclazocine, a drug previously discussed which blocks the effects of heroin.

(2). Use of oral methadone.

(3). Residence in long-term drug-free communities.

This pilot program became operational on January 1, 1968, and Dr. Jaffe was appointed its director. Since that time, the program has grown rapidly. By July 1, 1968, there were 108 individuals in treatment, all out-patients, and 2 facilities. On July 1, 1969, there were 301 individuals in treatment, 30 per cent in residence, 70 per cent out-patients and seven facilities. By September, 1969, it was recommended that the "pilot" concept be transformed into a fully operational program offering a wider range of services to a larger number of drug users. As a result, on July 1, 1970, there were 912 individuals in treatment, 22 per cent in residence, 78 per cent out patients, and 15 facilities throughout the state. In addition, there were 956 people waiting to enter treatment for the first time and 92 seeking readmission.

By the September of 1971, the program had approximately 2,200 persons in treatment, 20% in residence and 80% out-patients, and operated 21 facilities throughout the state. Seven of these facilities have residential capacities and 10 are operated in conjunction with private organizations which have contracted with the Department of Mental Health.

The program's current budget calls for an annual outlay of $3,000,000, which is relatively small when compared with the budgets of drug abuse programs in New York and California. Of this total budget, approximately two-thirds is funded by the Department of Mental Health and one-third comes from a five-year grant to the University of Chicago from the National Institute of Mental Health. Since there are an estimated 7,000 addicts in Illinois, staff members of the Illinois Drug Abuse Program project in the immediate future a need for an annual operating budget of $15,000,000 and a total complement of 63 facilities.

The Illinois Drug Abuse Program has achieved much of its success and international acclaim by its adherence to the concepts of multimodality treatment capabilities, flexibility, and innovation. For instance, the program has progressed from many single-modality treatment units to a point now where there are some units which provide all the available treatment modalities within a single facility. In addition, many units support both in-patient and out-patient activities, providing maximum efficiency from limited resources. A more specific description of the types of treatment units currently employed includes the following:

(a). *Pre-treatment or holding pattern units.* At present there is but one such unit, and it is considered a research effort. It is a dispensary offering no rehabilitative services other than methadone maintenance and its main function is to determine whether medication alone can help a patient avoid criminal activity while he awaits entry into a more comprehensive treatment unit. If it proves to be helpful, the holding pattern concept will permit the program to serve the large number of heroin-addicted persons who drop from the waiting list before they can be accommodated at a treatment facility. There are currently over 1,000 persons on the waiting list, and 70 per cent ultimately drop out. The waiting period is usually four to five months. Pre-treatment patients receive oral methadone daily under supervision. As in all units, urine testing is performed to check for the use of unauthorized drugs, and each week a certain amount of information about the individual's activities is collected.

(b). *Out-patient methadone clinics.* These clinics supply their patients with methadone support for an indefinite length of time. Weekly group therapy is an essential part of the treatment process and other services are provided when needed. When patients decide that they wish to become completely drug-free, they may be withdrawn from methadone either on an out-patient basis or in one of the residential facilities of the program. Thereafter, these patients can remain in their original treatment unit to take advantage of the supporting services.

(c). *The in-residence multimethod centers.* These are the most complex of the program's operations, primarily because they attempt to treat a highly heterogeneous patient population with vastly different methods within the same facility. These centers will accept methadone support patients who need a temporary, but highly structured, treatment setting, as well as individuals who elect immediate withdrawal from drugs and who remain in the centers as drug-free members. The stay at these centers is normally for six months.

Safari House, at 140-48 West 62nd Street, Chicago, Illinois, is one such multimethod center which was visited by representatives of the Commission. We learned that the staff of Safari House emphasized understanding the in-

dividual problems and circumstances of each patient. Efforts are made to lessen the "institutional" atmosphere of the facility by providing attractive interior furnishings and allowing for the development of individual interests. Some members of the staff are ex-addicts who demonstrate a deep personal understanding of the drug abuse problem and an intense dedication to helping the patients at Safari House.

(d). *Halfway House.* This unit is for patients from the various treatment settings who, after a period of residential care, have effectively come to grips with their heroin problem. It operates on both an out-patient and residential basis. There is less emphasis on group therapy because patients learn to operate effectively outside a group atmosphere, as they must do in the society to which they are returning. It is here that patients without skilled training or any work history prepare themselves for dealing with ordinary life situations, such as filling out an employment application.

Gateway House is virtually self-sustaining. Residents are called upon to provide all forms of construction and repair.

(e). *The in-residence, long-term drug free communities.* These facilities emphasize total abstinence and restructuring of character, and accept heroin and non-heroin patients. At present there are three such units operated by the Gateway Houses Foundation, a not-for-profit corporation originally established under the aegis of the program. Now operating semi-autonomously under a contract with the program, the Gateway Houses Foundation is able to receive additional support from private sources.

The intake information collected on Gateway residents is the same as that collected on all other program patients and, as a result, patients may be readily transferred to other units within the program.

Residents in Gateway Houses are required to remain drug free in a highly structured setting wherein group therapy, often in its more intense aspects, is practiced. All the operational functions of the community are performed by the residents themselves. Jobs are assigned according to the level of maturity demonstrated by each resident, beginning with the most menial tasks and progressing to supervisory positions.

Residents are reinforced against reverting to drug abuse by peer group pressure which acts to reward abstinence and maturity and censure self-pity and irresponsible behavior. For instance, when members of the Commission visited the Gateway House facility at 4800 South Ellis, Chicago, Illinois, they observed a girl waring a stocking on her head and bearing a large sign which read: "I am a child. I need guidance. Help me to grow up." This form of sanction is not common, but it is used as an effective last resort to discourage behavior which is damaging to the individual or to the therapeutic community.

The average stay at Gateway House is between 18 months and 2 years. After patients have been residents for approximately 12 months, and if they are ready, they may return to school for vocational training or a degree, or become employed, while maintaining their residence at the facility.

The final stage in the rehabilitation scheme involves both living and working in the outside community. During this phase there is but minimal contact with the therapeutic community as the patient is assimilated back into society. He may still attend the group therapy sessions, however.

The newest Gateway House facility, in Lake County, has added a new dimension to the traditional therapeutic community method. Located on a secluded 50-acre site on a wooded peninsula that juts into Fox Lake, this facility, a 25-room mansion formerly used as a retreat house by an order of Roman Catholic nuns, accommodates drug addicts and, for the first time, their entire families. Thus, the entire facility is unique: previously, Gateway House communities were established in inner-city ghetto areas and limited their membership to only the addicts

themselves. The new family-oriented approach allows the teaching of understanding and compassion to the addict's spouse and children so that those closest to him may contribute to his rehabilitation. It is emphasized that addiction is a disease which is exceedingly difficult to overcome, and that the resident-addict should be respected for his strength and determination. This family interaction not only contributes to the addict's rehabilitation, but also allows him to regain his functional role in the family unit.

Due to the length of time required for this form of treatment and the short time that the program has been operational, it is not possible to accurately assess the effectiveness of the Gateway Houses. However, since they are modeled after the Daytop Village in New York and Synanon in California, their experiences should be reasonable indicators of Gateway's expectation of success. In those programs, it was estimated that 80-85 per cent of those persons completing the treatment did not revert to drug abuse. However, the dropout rate prior to completion was rather high, often around 80 per cent.

(f). *Re-entry Clinic.* This clinic serves heroin-addicted persons who were members of other treatment units in the program and who left either voluntarily or involuntarily before treatment was completed. Methadone is dispensed; group therapy is mandatory; and social, vocational, and legal services are provided when necessary. The clinic staff is specially alerted to the problems that caused the patients to do poorly in their earlier attempts at treatment.

(g). *Treatment Units for Non-opiate Users.* At the program's first multimethod center, opened July 1, 1969, treatment for young non-heroin drug users was made available on a residential basis. Later, as an extension into the community, the program opened its first outpatient treatment unit for such drug users. This unit, primarily concerned with offering emergency and regular services, employs abstinence, group therapy, and phone therapy, and has a temporary residential capacity. At present, this unit is considered experimental in nature and its final structure has not yet been clearly defined.

While treatment units were initially concentrated on the south side of Chicago (where the immediate need was greatest), there are now units on the north side and the far south side of Chicago. In addition, several units have been established in the northern suburbs and in Peoria and Rockford. These units operate via a contractual arrangement which places them under the close supervision of the program, but they are actually run by local agencies. Wherever possible, these units have been located for the convenience of patients and are either within walking distance or easily accessible by public transportation.

These units are designed to provide a structure for productively supplying the patients with new activities, new associates, and new patterns of speech and behavior. They are also designed to be comfortable and to foster the feeling that they belong to the patients. The notion of belonging is particularly important since optimum program effectiveness requires the generation of involvement in the treatment process. Furthermore, the size of the patient population at any given unit is kept small enough to permit a sense of group identity.

To better implement the delivery of services, certain units are grouped into regions. There are currently three regions, and each has or will have a Central Clinic fully staffed to provide immediate backup services, crisis intervention and residential facilities to each of its outpatient clinics.

Five additional units are available to provide continuing supportive service to the present regions. They are the Medical Services unit, the Social Services and Vocational Rehabilitation unit, the Legal Services unit, the Community Organization unit and the Pharmacy. The Gateway Houses and certain other contractual operations and the Pre-treatment unit are considered non-regional.

The treatment manpower that supports this current effort totals 106 persons, 59 per cent of which are formerly addicted persons performing more than ably in many areas of crucial importance to the program. Working side-by-side with such people, but in collaborative and supportive capacities, are doctors, nurses, pharmacists, social workers, psychologists, and a toxicologist. In addition, the program has a training project through which capable persons interested in working in the area of treatment are identified and trained, creating a source of manpower to respond to narcotic abuse as well as non-narcotic abuse. The training cycle, lasting four months, seeks to develop staff who influence not only patients in the program but also people in the greater community. This offers a potential counter-force, not only to the symptoms of drug abuse but also to the psychosocial cause of such dehumanizing symptoms.

The program operates a special pharmacy which, through mechanized and automated procedures, mixes methadone, and then fills and labels bottles of this medication for patients. Currently, over 5,000 bottles of methadone are being so prepared weekly for over 700 patients. Because of the special problems attendant upon the use of methadone, considerable attention is paid to recordkeeping, security, and adherence to the general protocol under which the methadone components operate. Additionally, general non-methadone medication (e.g., vitamins) is maintained and dispersed by the pharmacy for use by the program's patient population.

The program also operates a laboratory where urine specimens are tested to determine whether patients have been using unauthorized drugs. The test can detect the presence of heroin and other related drugs as well as amphetamines, barbiturates and cocaine. In addition, this laboratory is seeking to develop new and better testing procedures for the detection of drugs. At present, more than 1,200 specimens are tested for heroin and related drugs each week. Several hundred of these specimens are also tested for amphetamines, barbiturates and other drugs.

Built into the program from inception was the capacity to evaluate the effectiveness of treatment methods and, hence, help to insure that changes in treatment policy would be based on solid evidence rather than conjecture. Such evaluation continues and currently involves the active manipulation of treatment procedures in an attempt to maximize treatment success.

Closely aligned to such evaluative activities are the program's research activities. These concern, for example, analyses of what factors may help to identify patients who do well under one method as compared to another, and the development of new treatment methods. Included here is research which seeks to: determine drug use trends in a drug distribution setting; examine the social structure that exists among addicted persons in such a setting; and measure the impact of the program's activities on drug addiction in that setting. Additionally, such research (termed epidemiological research) is used, in its exploratory capacity, for the planning of new facilities. There is also animal research which, among other tasks, concerns itself with the testing of different drugs to determine their abuse potential.

Where possible, the program makes use of computer techniques to merge, store, and print out—on a weekly basis—data utilized in the care of patients and the modification of treatment procedures. One print-out includes the current status of each patient along certain parameters: program type, self-reported drug use, laboratory reports of drug use, vocational status, income information, housing, medication being prescribed by the program, and the dose of medication prescribed. Another print-out includes a list of all patients ever in treatment, all patients now in treatment, which patients are in which treatment units and how long each has been in a particular unit, new patients entering each unit and patients leaving each unit. The age, race, sex, and legal pressure (if any) are also recorded for each patient. Such techniques assure that basic descriptions of the patient load are always immediately available. This feedback helps to spot small difficulties in the program before they become large problems.

The program seeks to respond to the information needs of the public. In responding to needs for information on drug abuse education, the program provides speakers, seminars, and written as well as audiovisual materials. Also, developmental work is being done for a major drug exhibit to be housed in the Museum of Science and Industry.

The Illinois Drug Abuse Program enjoys the reputation of being one of the most well-conceived programs of its kind in the nation. In the short time that it has been operational it has demonstrated:

(1). That it is possible to develop a multi-method treatment system within a single administrative structure.

(2). That such a system can reduce or eliminate much of the inefficiency and destructive rivalry which often characterizes the operations of single-method treatment programs in other communities.

(3). That where vested interests have not developed and treatment of narcotics users has not become politicized, people with widely different philosophies can communicate and actively cooperate with one another.

Preliminary evaluation studies indicate that arrest rates for the patient population have fallen dramatically that approximately two-thirds of the out-patients medically able to work are gainfully employed and that on any given week the use of unauthorized drugs, as determined by analysis of urine specimens, is less than 20% of the total out-patient population and less than 10% of all patients in treatment.

In the future, the program expects to expand into other communities of the state as funds and trained staff become available. Essentially, the program aspires to make treatment available to all persons who need it and on the very day it is requested.

Dr. Jaffe, testifying at the Commission's public hearings, explained that the future of the program depends primarily on the availability of additional funds and qualified staff personnel. He stated that a problem frequently encountered by many of the large, well-organized drug treatment programs throughout the country is the loss of key personnel to nascent programs which are able to offer higher salaries. Ironically, Dr. Jaffe himself has been lost to the Illinois Drug Abuse Program by his recent appointment by President Nixon to the new federal drug treatment program.*

There is currently a tremendous shortage of qualified people capable of replacing those who leave. It has been suggested that college instruction in addiction rehabilitation be accelerated to fill this gap, as more and more young people are turning to the social sciences for their field of study. On a local level, others have suggested the institution of a specialized training program in addiction treatment to qualify persons returning from Vista assignments and other areas of volunteer social work for careers in addiction treatment.

Also being explored for possible use in the future is the adaptation of standard personality testing devices to help determine the types of individuals best suited for the different modalities of treatment. This adaptation becomes more feasible as the addict population in the country grows larger and encompasses the classes of people who score most accurately on these types of tests. One phase of this adaptation might be the application of personality tests to members of the armed forces who have acquired an addiction problem while on duty overseas. With the problem of addiction in Viet Nam becoming increasingly serious, this application would be able to focus on a somewhat homogeneous statistical population of sufficient size and quality to derive meaningful results.

The following is a list of the names and addresses of the facilities currently operated by, or under the supervision of, the Illinois Drug Abuse Program:

Brass
418 E. 47th
Chicago, Ill. 60653

Drexel Research Clinic
5737 S. Drexel
Chicago, Ill. 60637

Foundation I
100 E. 154th St.
Harvey, Ill.

Foundation II
7400 W. 183rd St.
Tinley Park, Ill.

Gateway House
4800 S. Ellis
Chicago, Ill. 60615

Gateway House
6909 S. Gregier
Chicago, Ill. 60649

Gateway House
512 Cedar Crest Lane
Lake Villa, Ill.

Incentives
2424 Dempster
Des Plaines, Ill. 60016

Modality I (E. St. Louis)
(St. Clair County Council on Alcoholism & Drug Abuse)
4700 State St.
E. St. Louis, Ill.

North Side Clinic
887 W. Nelson Pl.
Chicago, Ill. 60657

(Peoria Clinic)
Stone Hedge, Inc.
5407 N. University
Peoria, Illinois

Pflash Tire Co.
1854 N. Sedgwick
Chicago, Ill. 60614

The Place
6022 S. Kimbark
Chicago, Ill. 60637

Preventimed
155 E. Ohio
Chicago, Illinois

Re-entry Clinic
7857 S. Stony Island Ave.
Chicago, Ill. 60649

Rockford Clinic
(Keyway House)
(Northern Ill. Council on Alcoholism & Drug Dependence)
311 W. Jefferson
Rockford, Illinois

Special Problems
1604 E. 79th St.
Chicago, Ill. 60649

Safari House
140-48 W. 62nd St.
Chicago, Ill. 60621

Seventy-ninth St. Clinic
1606 E. 79th St.
Chicago, Ill. 60649

Springfield Mental Health Center
1300 S. Seventh St.
Springfield, Ill. 62703

Tinley Park
Tinley Park Mental Health Center
7400 W. 183rd St.
Tinley Park, Ill.

Bethany Drug Awareness Clinic
341 S. St. Louis St.
Chicago, Ill. 60624

3. *Drug Abuse Service Program (City of Chicago).* The Drug Abuse Service Program is the drug treatment program proposed by the Chicago Board of Health. Still in the planning stage, the program would add specialized staff personnel to 18 currently existing mental health facilities throughout the city of Chicago. These units would provide services to their respective communities.

The program has two components: (1) direct services and drug education; and (2) an epidemiology component. The first would include outreach, crisis intervention, individual and

* His successor is Dr. Edward Senay.

group psychotherapy, emergency hospital inpatient care, referral, and rehabilitation follow-up care. The drug education programs will be directed at the potential drug user and his family, as well as others. Among the programs to be developed are lecture discussions for the general public, materials designed for presentation in the schools and in other places where the student population gathers, and special training seminars for community caretaker personnel — such as clergymen, police, school, medical, and nursing personnel.

The epidemiology component will have two functionally distinct aspects: (1) an assessment —evaluation mechanism; and (2) a medically oriented research activity involving the Division of Laboratories of the Board of Health. The assessment—evaluation approach will provide descriptive information about the persons being seen at the Community Mental Health Center. These data will be of a demographic nature and will include information such as age, sex, and ethnic group. The research activity will have two objectives: (1) identification of drug residues in the urine of consenting persons seen at the Community Mental Health Center; and (2) the designation of one or more suitable cohorts for drug consumption epidemiological research. The data that will be generated will be useful in developing a careful, comparative assessment of the scope and spectrum of drug abuse phenomena as they currently exist in Chicago.

The program is designed to compliment the services now offered by the state-operated Illinois Drug Abuse Program. It will stress the mental health aspects of the drug abuse problem, offering psychotherapy and counseling services. It will also emphasize the "soft" drugs, i.e., drugs of the barbiturate, amphetamine or hallucinogenic types. It will not offer methadone treatment, since methadone is only effective for addiction to the opiate variety of drugs. It will attempt to avoid, where possible, needless duplication of those services offered by the Illinois Drug Abuse Program.

The proposed program has an estimated annual budget of $1,425,097. The Board of Health has requested a grant of over $1,000,000 from the Chicago Committee on Criminal Justice. That committee will recommend the program for federal funding to the Illinois Law Enforcement Commission. The remainder of the budget will be funded by the Board of Health.

Dr. Vladimir Urse, assistant to the Commissioner of Health for Mental Health, has been named project director. However, since Dr. Urse has recently been taken ill, he has temporarily been replaced by Dr. Thomas F. McGee, a psychologist, who is director of the Mental Health division of the Board of Health. Dr. McGee explained to the Commission that an ad hoc Inter Agency Council on Drug Abuse has been established to coordinate city, county and state drug treatment efforts. This Council will work closely with the Dangerous Drugs Advisory Council on the state level.

4. *Youth Services Department (Cook County).* Cook County Sheriff Richard J. Elrod recently announced the formation of a citizens' advisory group to help combat drug abuse among young people throughout Cook County. The function of the advisory group will be to educate parents, teachers, and police about the drug problem, and attempt to coordinate the efforts of existing anti-drug programs in Cook County in an effort to make these programs more effective.

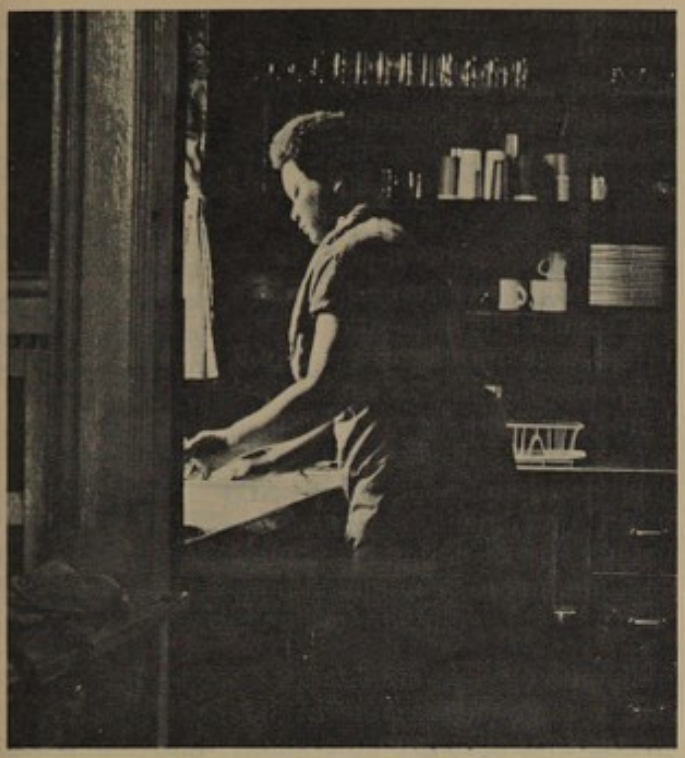
The advisory group will work with the newly-formed Youth Services Department, which came into existence on March 1, 1971 to deal with juvenile problems on a countywide basis. This Department, headed by Dr. Bernard Dolnick, has been given an operating budget of $95,000 from the Cook County Circuit Court Committee on Help for fiscal 1971.

Sheriff Elrod has explained that the Youth Services Department and the advisory group will not be an arm of the sheriff's law enforcement function. Instead, it will emphasize preventing the expansion of the drug problem through education.

In the future the Department hopes to establish a 24-hour referral service staffed by physicians to whom law enforcement officials in the county and parents can turn when youngsters who have taken an overdose of drugs are found or arrested.

5. *Narcotic Addict Rehabilitation Act (NARA) 1966.* Illinois is a beneficiary state under the federal Narcotic Rehabilitation Act (NARA) of 1966. This law provided, for the first time, that a complete range of rehabilitation services be made available to addicts in their own communities. The NARA is now being implemented, but full services to addicts are still not available throughout the country.

The Rehabilitation Act provides that: (1) Certain addicts charged with specific federal offenses may be committed for treatment instead



Work is an essential part of the treatment program at Gateway House. Residents are kept busy and involved.

of being prosecuted for their crimes in the courts. They are assigned to the Surgeon General of the Public Health Service for examination, treatment, and rehabilitation; (2) Some addicts already convicted of certain crimes can be committed by the court to the Surgeon General for a treatment period of no more than 10 years or for the maximum period of sentence that could be imposed for his conviction; (3) An addict not charged with an offense can be civilly committed to the Surgeon General for treatment upon his own application or the application of a relative or another "related individual" (any relative by blood or marriage, or the person with whom he resides) being presented to the local U. S. Attorney; for specialized training programs and for the construction, staffing, and operation of new addiction treatment facilities on a joint federal-state basis.

Under the provisions of the Rehabilitation Act, approximately six months are spent in treatment at the federal hospital for addicts in Lexington, Kentucky. The remaining time is spent in the home community with counseling and other out-patient services provided by local agencies under contract with the federal government. Three such agencies in the Chicago area are the following:

(1) Family Service Association of Oak Park and River Forest (FSA), located at 124 South Marion Street, Oak Park, Illinois 60632 (383-6266). This facility is directed by Mr. Donald Woolf and has been offering its limited services to both "soft" and "hard" drug users since 1969. It receives $48,000 annually from NARA, and $46,000 from the Oak Park-River Forest Community Chest.

FSA accommodates out-patients only. It processes approximately 100 patients annually with its limited staff of five full-time and two part-time employees. There are currently 17 patients in treatment. Its program requires total abstinence from drugs; and methadone maintenance is not offered. Instead, FSA emphasizes individual and group therapy, incorporating drug users into its larger group of patients who are receiving therapy for non-drug-related difficulties.

The majority of FSA's drug patients are assigned from the Lexington Federal Hospital. About 5 per cent relapse into drug use and are returned to the hospital for further treatment.

(2) Near North Family Guidance Center, located at 12 East Walton Street, Chicago, Illinois 60611 (943-6545). Among its services this Center provides profession therapy sessions for many of the agencies dealing with drug and runaway problems, in-and-out patient treatment, methadone treatment, individual-group-family therapy, community education and informational services. Fees are charged for some services.

(3) St. Leonard's House, located at 2100 West Warren Blvd., Chicago, Illinois (738-1414). The House is self-advertised as a "house for released prisoners" and is directed by Mr. Louis Randell. Its total annual budget is $250,000 which is derived from NARA, OEO, the local Episcopal diocese, (which is its sponsor) and from private donors.

Situated in the heart of the near West Side black ghetto, its staff includes medical and psychiatric doctors, lawyers, chaplains, and social workers. Its physical facilities include 21 individual sites expanding through the neighborhood from the original building at 2100 West Warren Blvd.

The House treats about 200 patients per year, including 36 from the Lexington Federal Hospital. It offers both out-patient and in-patient services. The average stay is three months and the dropout rate from the residency program is only about 1 per cent.

There is no methadone program offered. Rehabilitation is accomplished solely through therapy, in either individual, group, or family-oriented programs. Vocational guidance is offered in cooperation with the Illinois State Employment Service.

Its purpose is to deal with the social, physical, and emotional needs of offenders and ex-offenders in the Chicago area, especially those residing on the near west side. Its programs make use of professional knowledge, skills and attitudes to alleviate problems experienced by persons having difficulty with the law.

6. *The Illinois Department of Corrections.* Recently, Mr. Peter B. Bensinger, Director of the Illinois Department of Corrections, announced that his Department was instituting a new approach to the treatment of narcotic addicts who had been placed in his custody through the juvenile or criminal courts. The new program will attempt to involve the community and the various parole agencies in supervision of the narcotic offender and a meaningful plan for treatment, evaluation, training and counseling upon his release.

The initial operation of this program began with the opening of the first facility in Chicago. It is designed to handle work-release prisoners and parolees at a community base center, offering residence, counseling, and a specialized effort at preventing a return to addiction. The Parole and Pardon Board maintains a careful observation of the offenders and establishes conditions for their release.

The Department has received a grant of $200,000 for use in this program. This will enable an estimated 80 of the Department's addict population to participate in the program the first year. Specific information and advice has been obtained through the Illinois Drug Abuse Program. After the first year of operation an evaluation will be made as to the program's effectiveness, and at that time the program may be expanded to serve all 300 of the addicts now in confinement.

We believe that Mr. Bensinger's program for addict-prisoners holds great potential for success. It is likely to enjoy all the advantages of the various civil commitment programs in other states, while being unburdened by those programs' traditional difficulties, such as constitutional challenges and habeas corpus allegations. Under the professional advice of the Illinois Drug Abuse Program, the new Department of Corrections drug treatment effort promises to be a major contributor to the eventual rehabilitation of all drug addicts in our State. We commend the efforts of that Department and urge cooperation by the appropriate state officials to ensure its future expansion and success.

7. *Other treatment programs.* There are many other private treatment programs in Illinois, most of which are located in the Chicago area. The descriptions of the programs are listed below in those instances where they were provided by the respective organizations.

(1) Another Way, Inc., 5252 North Western Avenue, Chicago, Illinois, telephone 876-1166, offers guidance, counseling and educational services for both poly-drug and hard drug abusers. The program uses group therapy methods involving youths, youths and parents, and a "Parents Anonymous" group. Also offered are training services and a 24-hour telephone service. Services are offered to all ages in the metropolitan community, and the fee is based on income.

(2) Cermak Memorial Hospital, House of Correction, 2800 South California Avenue, Chicago, John C. Meade, Director, telephone 247-6200.

(3) Concepts West, 6700 South Crandon, Chicago, 60649.

(4) Concerned Community Response to Drug Abusers, YMCA, Berwyn, Pete Degree, Director. An educational program for young and old; professional emergency medical care for drug treatment; individual and group counseling.

(5) Drug Abuse Council, P. O. Box 411, Downers Grove, 60515.

(6) Drug Concern Committee, Jewish Federation Agencies, 1 South Franklin Street, Chicago, 60606, Contact is Dr. Ralph K. Meister.

(7) Du Page County Advisory Council on Drug Education, Box 429, Wheaton, 60187. Provides leadership and a coordinated approach to the total problem of drug education for the prevention of drug abuse. The proposed activities include the establishment of emergency drug service at hospitals; a 24-hour answering service; seminars for adults; educational devices for children on the dangers of drugs.

(8) Emerald City, 1056 West Lawrence Avenue, Chicago, telephone 878-6769. A new service that provides crisis response, telephone and in person counselling, referral, and volun-

teer training. Serves Uptown, Rogers Park, and other communities for poly-drug use. It is affiliated with the Uptown YMCA.

(9) Englewood and South Shore Drug Abuse Program, Youth Action, 6542 South Halsted Outpost and 7124 South Jeffrey Outpost, Chicago, Jorga English, Director. Meetings are held at both sites to discuss ways and means of dealing with drug problems and mental health disorders.

(10) Family Service Association of America, 221 North La Salle Street, Chicago, telephone 263-7229. This is a federation for more than 325 non-profit, voluntary family social services in North America, headquartered at 44 East 23rd Street, New York, New York 10010. It provides family counseling on many problems, including drug abuse.

(11) The Forest Home, 555 Wilson Street, Des Plaines, telephone 827-8811, Dr. Robert Simon, Director. Offers in-patient and out-patient psychotherapy for drug abusers. Detoxification is followed by individual counseling and group therapy. There is no methadone program yet, but one is expected to be started in the near future. Cost for drug treatment is the same as for other forms of psychiatric therapy, often as high as $600 per week for in-patient care, and $120 per month for out-patient treatment.

(12) Help, Adolph Meyer Zone Center, East Mound Road, Decatur 62526, telephone (217) 423-4357. Contact is Danny Taylor.

(13) High School Outreach Work (H.O.W.) Southwest YMCA, Chicago, Gil Schauer, Director. Helps youth between the ages of 13 and 17 who are in trouble with the law, youths on drugs, parents and interested citizens. It attempts to develop alternatives to drug abuse, and offers appropriate guidance counselling.

(14) Illinois State Psychiatric Institute, 1601 West Taylor Street, Chicago, Jerome Goldberg, Director, telephone 793-2572.

(15) Jacksonville State Hospital, 1210 South Main Street, Jacksonville, Dr. Steve Pratt, Superintendent, telephone (217) 245-2111.

(16) Kankakee State Hospital, 100 East Jeffrey Street, Kankakee, telephone (815) 932-7433.

(17) Logan Square — Avondale Youth Resource Network, 2641 North Milwaukee Avenue, Chicago, telephone 583-6969. It offers counseling, group therapy, rescue service, and community organizing and is affiliated with the Logan Square Neighborhood Organization.

(18) Looking Glass for Runaways, 1725 West Wilson Avenue, Chicago, telephone 334-2601. It offers a 24-hour hot line service; crisis intervention; immediate legal, judicial or psychological assistance through its own staff or through referrals; group and individual counselling, housing, and medical aid. It is affiliated with Travelers Aid.

(19) Manteno State Hospital, Manteno, John Salisbury, Director, telephone (815) 808-3451.

(20) Mile Square Project, 2049 West Washington Street, Chicago 60612, telephone 942-5722. This is a neighborhood health center in a one mile square area of the black ghetto. Funded by the United States Office of Economic Opportunity, it provides extensive health, education, and other social and economic family and community services including youth programs directed against drug abuse.

(21) National Center for Youth Outreach Workers, 826 South Wabash, Chicago, 60605, telephone 922-6925. It was established by the National Board of the YMCA of the United States of America, and funded by a grant from the United States Department of Health, Education and Welfare. It provides training for outreach workers for youth-serving agencies such as the YMCA, Boys' Club of America, and Settlement Houses. Drug Abuse is part of the course of instruction for future counselors.

(22) Prevention, Inc., 1366 North Hoyne Avenue, Chicago, telephone 252-7888. Tries to give meaningful directions to drug addicts, alcoholics, prostitutes, teen gang members, and juvenile delinquents. Members must spend 2-3 months in residency, going through drug withdrawal, attending Bible classes and chapel, and taking part in a work program and local YMCA programs. Members are referred to Teen Challenge upon completion.

(23) Program in the Area of Drug Use and Abuse, YMCA, 1515 South Touhy Avenue, Park Ridge, Jim Hojanacki, Director, telephone 825-2171. Offers crisis intervention, counseling, seminars, current information education, streetwork, referrals and youth programs.

(24) Sunshine Aide of Greater Lawn Mental Health Center, 5635 S. Pulaski Road, Chicago, 60629. Offers hot-line, crisis-intervention, referral, counseling and walk-in services. It closed temporarily in August 1970 for lack of

funds but it will be reopened when funds become available.

(25) Synergy, 905 South Illinois Avenue, Carbondale, 62901, telephone (618) 536-2311. Its purpose is to provide a drug crisis center, particularly one that is available in the evening hours, and continuing educational programs which reach out, inform and operate on a referral basis to make the largest contribution with the resources available.

(26) Teen Challenge, 315 South Ashland Avenue, Chicago, Rev. Kenneth Schmidgall, Director, telephone 421-0111. This is a religious approach organization with live-in facilities. After detoxification, drug addicts are sent to vocational training centers. It also offers a 24-hour telephone service.

(27) Tri-City Youth Project, YMCA, Elgin. It has branches at St. Charles, (James Weaver, Director, telephone 584-5325); Geneva, (John Lengle, Director, telephone 232-7644); and Batavia, (Gerry Epp, Director, telephone 879-3695). This organization is a consolidation of the Detached Workers of St. Charles, the Geneva Youth Project, and the Batavia Youth Project. It provides formal and informal counseling on drugs and other youth problems. Members range from adolescents to high school age, and there are a few college students and young adults.

(28) Valley Outpost Clinic, 2067 West Roosevelt Road, Chicago, Dr. Edsel K. Hudson, Director, telephone 663-5338. Offers free clinical care to persons in the "Valley" area bounded by Roosevelt Road, 16th Street, Ashland Avenue and Western Avenue. The clinic is sponsored by the University of Chicago.

(29) West Side Organization, Rehabilitation Educational Drug Abuse Program (Re-Dap), 1527 West Roosevelt Road, Chicago, telephones 226-4298 or 341-8100, extension 8145. Offers detoxification, hospitalization (in conjunction with the Illinois State Psychiatric Institute), maintenance, individual and group counseling, and community education. It charges membership dues.

(30) Winnebago County Medical Society, 310 North Wyman Street, Rockford, 61101, telephone (815) 963-9673. Among the usual services and functions performed by medical societies, this particular organization also provides referral, educational, informational and medical management services for drug users.

(31) Youth Help Center, Grace Lutheran Church, 555 West Belden Street, Chicago, telephone 929-3553. Offers crisis intervention, 24-hour telephone service, counseling, housing (with parents permission), and referrals. Focuses on youth under 18 and offers a training program for youth center staffs.

8. *Hot-Line Telephone Services.* Emergency telephone services have been established by agencies, community groups, and individuals to aid young people and adults during drug crisis periods or when they have had a "bad trip." The offer advice and understanding and refer problems which call for professional help to the appropriate persons or agencies.

In Chicago:

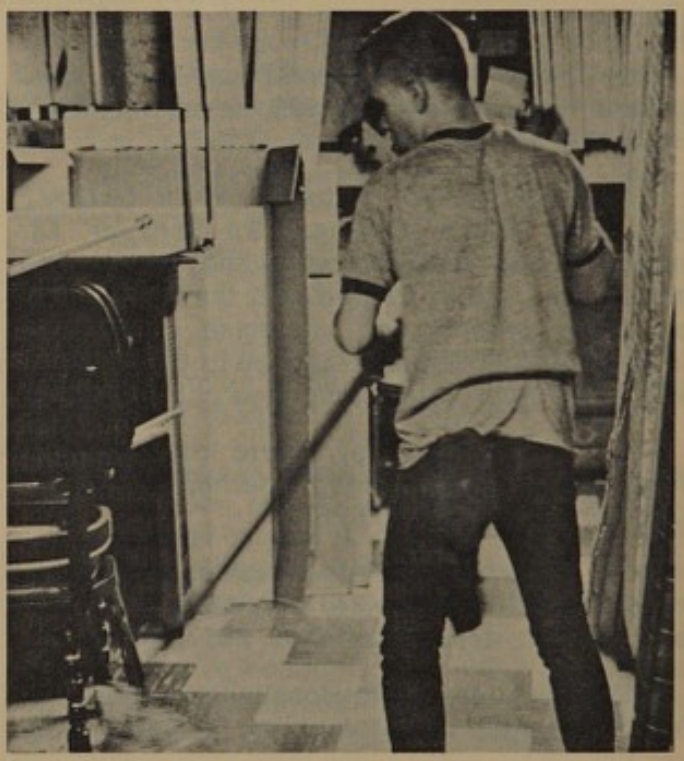
(1) Another Way, Inc., 878-1166.

(2) Drug Action Line, 222-4365, 6:30 a.m. to 9:00 p.m. daily, Dick Cheverton, Coordinator.

(3) Emerald City, 878-2769.

(4) Inner Tube, 777-0545 and 0546.

(5) Kool Aid, Youth Emergency Rescue Service, 644-0505.



New residents are given the most menial tasks at Gateway House. As they progress in motivation and maturity, they are given more important jobs with greater attendant status.

A major innovation of the Gateway Foundation has been the establishment of a drug treatment facility in Lake County. Here the addict and his family undergo the rehabilitation program together under the same roof.

(6) Logan Square — Avondale Youth Resource Network, 585-6969

(7) Looking Glass, 334-2601.

(8) LSD Rescue, 761-1034.

(9) Pflash Tire, 664-4041, 4042, and 4043.

(10) Prevention, Inc., 252-7888.

(11) Survival Line, 285-7844, from 9:00 a.m. to 5:00 p.m.

(12) Youth Help Center, 929-3553.

North Suburban Cook County:

Evanston
Hot Line, 866-9500, Northwestern University Drug Council.

Niles
Youth Aid Telephone Service, 775-2211, Leaning Tower YMCA.

Maine Township
Hot Line, 825-0860, Park Ridge and Des Plaines' Coordinating Council.

Mount Prospect
Pump House, 259-7184, local community sponsorship.

Palatine
The Bridge, 359-7490, Palatine Township Youth Committee.

Lake Forest
Drug Alert, 295-1063, Drug Alert Committee.
Drug Information and Rescue Service, 295-2929, Lake Forest College.

Elk Grove
Listening Post, 439-0500, Elk Grove Community Services.

Southwest Suburban Cook County:

Oak Lawn-Evergreen Park
Memphis Head Rest, 499-2900, H. O. W. Board, Inc.

Far South Suburban Cook County:
Hot Line, 754-9030, community sponsored.

West Suburban Cook County:

Oak Park
Hot Line, 848-2555, township sponsored.

Proviso Township
Hot Line, 345-3920, township sponsored.

Lombard
May Talk, Dial M-A-Y-T-A-L-K, Lombard Council on Drug Abuse.

Downers Grove
Drug Action Line, 852-0110, local drug committee.

Naperville
Hot Line, Dial 355-H-E-L-Px YMCA sponsored.

Geneva and Batavia and St. Charles
Life Line, 584-1526, Tri-City Youth Project, YMCA.

Aurora
Youth Aid Program, 859-3333, YMCA affiliate.

Elgin
Y.E.S. Youth Emergency Service, 697-0550, community sponsored.

9. *Information and referral services.* Information about drugs and drug abuse, and referrals to appropriate treatment or rehabilitation agencies are offered to the public by the following organizations:

(1) American School Health Association, Box 416, A.S.H.A. Building, Kent, Ohio 44240.

(2) Catholic Charities of Chicago, Addiction Consultation and Educational Services, 126 North Des Plaines Street, Chicago, Illinois 60606, Rev. Msgr. Ignatius McDermott, Director, telephone 236-5172, extension 335.

(3) Central States Institute of Addiction Programs, 126 North Des Plaines Street, Chicago, Illinois 60606, Joseph A. Bou-Sliman, Director, telephone 236-5172.

(4) Chicago Department of Human Resources, Youth Services Division, 640 North La Salle, Chicago, Illinois 60610, telephone 744-4047.

(5) Community Referral Services, Welfare Council of Metropolitan Chicago, 123 West Madison Street, Chicago, Illinois 60602, telephone 372-6911.

(6) Cook County Coordinating Council on Drug Education, Cook County Department of Public Health, 1425 South Racine Avenue, Chicago, Illinois 60608, telephone 243-5832.

(7) Illinois Pharmaceutical Association, Drug Education committee, 4201 West Lawrence Avenue, Chicago, Illinois 60630, telephone 736-5483.

(8) Illinois State Medical Society, Committee on Narcotics and Hazardous Substances, 360 North Michigan Avenue, Chicago, Illinois 60601, telephone 782-1655, Dr. Joseph H. Skom, Director.

(9) Mental Health Association of Greater Chicago, 407 South Dearborn Street, Chicago, Illinois, telephone 922-0703.

(10) National Association of Boards of Pharmacy, 77 West Washington St., Chicago, Illinois 60602, telephone 263-6540.

(11) National Clearinghouse for Drug Information, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

(12) National Coordinating Council on Drug Abuse Education and Information, Inc., 1211 Connecticut Avenue, N. W., Washington, D. C., 20005.

(13) The Student Association for the Study of Hallucinogens, 638 Pleasant Street, Beloit Wisconsin 53511.

(14) Student American Medical Association, 1400 Hicks Road, Rolling Meadows, Illinois 60008.

(15) Travelers Aide, 22 West Madison Street, Chicago, Illinois, telephone 782-0950.

(16) U. S. Government Book Store, Federal Building, 219 South Dearborn Street, Chicago, Illinois 60604, telephone 353-5133.

Conclusion

Until recently, the public had regarded addicts as incurable. Once "hooked," there was no road back to society. This belief arose from the fact that many opiate addicts relapsed to drug use even after long periods of hospitalization and abstinence. Not long ago, treatment for addiction consisted of little more than withdrawal from the drug and detoxification. When more ambitious programs were attempted, they had only limited success in terms of "cured" addicts, but each contributed to knowledge about the addict, the drugs he used, and ways to effect his rehabilitation.

Today, there is general agreement that a successful state treatment approach should include programs of many modalities. Controlled detoxification in a hospital environment should be available along with psychiatric evaluation and therapy, and continued medical supervision and counseling upon the addict's return to the community. Where suitable, ambulatory forms of treatment should be utilized.

Alternatives to immediate, complete withdrawal are currently being explored in the form of chemotherapy. New drugs such as methadone, methadol, and other substitutes may be useful in deferring withdrawal while rehabilitating the addict's emotional makeup. Narcotic antagonists such as cyclazocine and pentazocine which block the effects of opiates, may also be of tremendous clinical use in the treatment of addiction. The greatest advantage of these ambulatory programs is that large numbers of addicts can be treated with minimal institutional facilities being maintained by the State. Moreover, most patients are able to make speedy returns to productive roles in society. Other "savings" are realized by the state in the form of discontinued criminal careers by addicts who no longer have to steal and rob to maintain their habits.

Unfortunately, no comparable form of treatment has yet been devised for the non-opiate addicts. The crush of addiction to stimulants and depressants in recent years has far exceeded medical science's ability to cope with the problem. A form of chemotherapy for these addicts is urgently needed.

Much the same can be said for the dearth of treatment programs available for persons dependent upon or mentally scarred by marihuana and the psychedelic drugs. Except for emotional therapy and religious counseling there are no treatment modalities available to these drug victims.

For those addicts with unusually strong ego development the therapeutic community approach as exemplified by Chicago's Gateway House may be the best approach. This program is available to persons hooked on heroin as well as other addicting drugs. The difficulty, of course, with this modality is its selectivity. Since most people cannot endure the emotional stress of personal confrontation practiced in such communities, this obviously cannot be the prescribed form of treatment for all addicts.

For the hard-core drug addict who resists rehabilitation efforts and refuses to cease his self-destructive activities, incarceration seems to be the only alternative. Either in the form of imprisonment ancillary to some criminal violation or civil commitment, this last resort is the only way of separating the individual from his suicidal use of drugs. Unfortunately, it is the least effective form of treatment since the addict has little or no motivation to rehabilitate himself.

Legalization of drugs and attempts at government regulation of distribution comparable to the "British System" have been unqualified failures. To resurrect this concept in any form is to invite disaster.

It is difficult to determine which modality of treatment will prove most effective for a given individual. Undoubtedly all of the existing treatment methods in the United States will some day take their places in the mosaic of treatments which can be utilized in connection with this problem. Although we are very far at this point from having the method which would cure all addiction, there are some encouraging signs.


FEED YOUR
HEAD

Chapter 10
BRIEFING FROM FEDERAL AUTHORITIES

On October 7, 1970, a delegation of the Commission traveled to Washington, D.C. where the members were received by various federal authorities. The visit was for the purpose of receiving a one day briefing on all aspects of the drug problem. During its stay the Commission was hosted by the U. S. Department of Justice and the Federal Bureau of Narcotics and Dangerous Drugs.

United States Department of Justice

The Commission received its initial briefing from United States Deputy Attorney General Richard Kleindienst. Mr. Kleindienst told the Commission that narcotics and dangerous drugs enforcement has become a consuming interest of the United States Department of Justice. He outlined the various steps taken by all agencies in the Federal Government to provide a unified comprehensive attack on the drug problem. Major emphasis was placed on the new Federal Drug Act which was drafted under the direction of the Department of Justice.

Mr. Kleindienst expressed particular alarm and fear over the nature and extent of hard-core drug addiction and the accompanying commission of crimes to pay for such addiction. He noted that it is clear that the heroin problem no longer is confined to the ghetto or to citizens in the lower social economic groups of our society. He said that no single group in the United States has a monopoly on either crime or the misery and losses resulting from crime. He suggested that the drug problem is both a state and national concern. For this reason long range planning, coordination and innovative legislation are absolute necessities. He said that for too long, government's response to the drug crisis has been piecemeal and truncated.

In addition to speaking with Mr. Kleindienst, the Commission also met with Associate Deputy Attorney General Harlington Wood, a native of

Springfield, Illinois and former Commission member.

Bureau of Narcotics and Dangerous Drugs

The major portion of the Commission's visit to Washington was spent at the headquarters of the Federal Bureau of Narcotics and Dangerous Drugs (BNDD). During its stay the Commission was hosted by Mr. John E. Ingersoll, Director, Mr. Andrew C. Tartaglino, Assistant Director for Enforcement, and Mr. Donald Miller, Chief Counsel to the Bureau.

The Bureau of Narcotics and Dangerous Drugs was established on April 8, 1968. It resulted from the merger of the Treasury Department's Bureau of Narcotics and The Food and Drug Administration's Bureau of Drug Abuse Control. The Bureau was established to more effectively control narcotic and dangerous drug abuse through enforcement and prevention. The Bureau is responsible for the enforcement of federal laws relating to narcotic drugs, marihuana, depressants, stimulants, and the hallucinogenic drugs. Its objectives are to arrest major interstate and foreign sources of supply and to seize the greatest quantity of drugs abroad before they reach the streets of America's cities. To achieve its mission, the Bureau has stationed highly trained agents along the traditional routes of illicit traffic, both in the United States and in foreign countries. (The Commission's Executive Director pioneered this task).

Besides enforcing the laws, the Bureau also regulates the legal trade in narcotic drugs. This entails establishing import, export and manufacturing quotas for these controlled drugs. Physicians, pharmacists, and other persons responsible for handling, dispensing, or prescribing narcotics and dangerous drugs may be subject to periodic inspections by BNDD representatives. Such supervision of legitimate trade insures adequate supply of drugs for medicinal purposes and research, and at the same time is instrumental in preventing diversion of drugs into illicit channels.

Another area of responsibility for the Bureau of Narcotics and Dangerous Drugs is drug abuse prevention. As part of its program to make citizens aware of the hazards of narcotics and dangerous drugs, the agency provides factual information through literature, speakers, films, and displays to a variety of organizations, and to the general public. It also works closely with educators as well as many local, state, and national government agencies, associations, law enforcement offices, and organizations in planning and conducting abuse prevention programs.

The Bureau regularly responds to requests for investigative assistance from state and local authorities and provides laboratory analyses of drug evidence and related expert testimony in court.

In an attempt to accumulate current information regarding the drugs under its jurisdiction, the Bureau encourages and sponsors controlled scientific research in the field of drug abuse. This is an extremely important program in that field and encompasses clinical, social, psychological and biological research. The Bureau also calls upon its Scientific Advisory Committee on Drugs for opinions regarding whether or not certain new drugs should be brought under control.

As a part of its tour of the headquarters building, the Commission inspected the Bureau's National Training Institute. This institute conducts intensive training in narcotic and dangerous drug law enforcement for law enforcement officers from agencies throughout the United States. Ten-week schools are conducted in which police officers receive training similar to that which BNDD special agents receive. In addition, they are introduced to management concepts which will enable them to develop and lead drug investigative units and organize drug prevention programs in their communities. Specialized two-week schools for police officers are conducted by the National Training Institute in Washington, D.C. throughout the United States and in foreign countries.

Special seminars are conducted for college deans and campus security officials, military police, forensic chemists and industrial and civic groups at the Institute and at various locations in the United States.

Narcotics and Dangerous Drugs

Assistant Director Tartaglino gave the Commission a brief analysis on the various narcotics and dangerous drugs which represent the greatest problem in the U.S.

1. *Narcotics.* Narcotics as a class of drugs have caused the greatest concern to the Bureau. A narcotic is a drug that relieves pain and induces sleep. The term "narcotic" gen-

erally refers to opium and drugs made from opium, such as heroin, codeine, and morphine. These drugs are distilled from the juice of the base of the poppy flower and refined into several of the most valuable medicines known to man, but also some of the most abused drugs in the world. In addition, other drugs have been included under the federal laws as "narcotics," which are not properly classified as narcotics. An example of this is cocaine, which is a derivative of the coca leaf and a stimulant to the central nervous system. Additionally, a number of specially designed synthetic drugs are also classified as narcotics under the federal law.

The most significant narcotic is heroin, which is morphine chemically altered to make it about six times stronger. Heroin accounts for about 90 per cent of the narcotic addiction problem. It has no recognized medicinal use in the United States. All heroin found in America is smuggled into the country. It produces both physical and psychological dependence. Heroin users have been known to become "hooked" after using the drug daily for less than a week. Perhaps 200,000 Americans are now using heroin, possibly 100,000 of them in New York City alone. John Finlator, Deputy Director of the Bureau of Narcotics and Dangerous Drugs, thinks that the figures could be even higher than this.

2. *Marihuana.* A second major drug of abuse is marihuana. All marihuana comes from the Indian hemp plant known as Cannabis Sativa L. The plant grows in mild climates throughout the world, especially Mexico, Africa, India and the Middle East. It also grows in the United States. In fact, many large fields of marihuana have been found and destroyed in Illinois in recent years. The active ingredient in marihuana which produces the physiological reaction in the body is tetrahydrocannabinol. The parts with the highest tetrahydrocannabinol content are the flowering tops of the plant. The leaves have a smaller amount. The stalks and seeds have little or none.

The potency of the drug ranges from limited effects from poorly harvested marihuana to the severe effects of hashish. Hashish, or "hash," is the dark brown resin that is collected from the tops of the hemp plant. It is at least five times stronger than cannabis used in marihuana cigarettes.

As generally used in this country, marihuana is a mild drug producing a feeling of relaxed well being, a "high" and sometimes fantasies or hallucinations. It is not a narcotic although it was once so classified under Illinois law and it does not lead to physical dependence or addiction. It may, however, lead to psychological dependence or desire. Under the use of marihuana, time stretches out, distances and sounds are magnified and reflexes are slowed.

A recent survey conducted by the National Institute of Mental Health shows that almost one third of college students have tried pot, with some 14 per cent using it regularly. Another estimate is that 12 million to 20 million Americans have tried marihuana at least once. The World Health Organization estimates that more than 200 million people around the world use marihuana regularly.

3. *Hallucinogens.* A drug classification which has caused growing alarm is that of hallucinogens. Hallucinogens, which are also called psychedelics, are drugs capable of provoking changes of sensation, thinking, self-awareness and emotion. Alteration of time and space perception, illusions, hallucinations and delusions may be either minimal or overwhelming depending on the dose. The results are extremely variable; a "bad trip" or a "freak-out" may or may not occur in the same person on different occasions.

LSD is by far the most potent hallucinogen. With this synthetic chemical, a dose no larger than the point of a pin is enough to send most people off on amazing "trips" within their own minds, with emotional experiences and observations greatly magnified. Some people react with anxiety. Others, such as the daughter of TV personality Art Linkletter, have been fatally injured in the belief that they were invulnerable to injuries. No physical dependence develops, but psychological dependence may occur through repeated dosage.

Tragically, LSD can be manufactured in an amateur chemistry lab costing less than $1,000. On today's wholesale market an ounce of LSD sells for $1,000. This equals 4,000 dosage units or "tabs," at $5 each.

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

Besides LSD, a large number of synthetic and natural hallucinogens are known. The nat-

ural psychedelics include mescaline from the peyote cactus, psilocybin from certain Mexican mushrooms, morning glory seeds and others. The synthetics, frequently referred to as the "alphabet drugs," include DMT, STP, MDA, PCP and many others.

4. *Stimulants.* Stimulants are drugs which increase alertness, reduce hunger, and provide a feeling of well-being. Their medical uses include the suppression of appetite and the reduction of fatigue or mild depression. As indicated previously, cocaine is properly classified pharmacologically as a stimulant even though it is frequently defined as a "narcotic" in many statutes. There are many other stimulants in addition to cocaine. These include the amphetamines, dextroamphetamine, and methamphetamine.

Stimulants directly stimulate the central nervous system. The most widely know stimulant in this country is caffeine, an ingredient of coffee, tea, cola and other beverages. Since the effects of caffeine are relatively mild, its use is socially acceptable and not an abuse problem. The synthetic stimulants such as amphetamine, methamphetamine, phenmetrazine and other closely related drugs are more potent and can be abused.

Cocaine is often abused in combination with other drugs. When taken, these stimulants produce excitation, increased activity, and an ability to go without sleep for extended periods of time. The drug has lately become used more and more because of its local anesthetic qualities in conjunction with sexual performance.

Amphetamines, according to current research, increase the availability of noradrenalin in the nerve cell connections. This is particularly true in areas of the brain associated with vigilance, heart action, and mood. Excessive stimulation of these brain cells is normal under emergency life conditions, but when it is prolonged by amphetamines undesirable secondary changes develop. Overdose of amphetamines initially produces a sense of good feeling, of boundless energy and of never feeling tired — but there comes a time of physical and emotional "payoff." Methamphetamine or "speed" is especially potent, particularly when injected. Many experts regard methamphetamine as the most dangerous, mind-shattering and potentially fatal drug available today.

Stimulants are usually taken by most users in the form of capsules or tablets. Crystal methamphetamine and cocaine can be inhaled or "snorted" through the nostrils. They can also be injected into veins, in which case the effects are immediate and more intense.

5. *Depressants.* Depressants, which are sometimes referred to as sedatives or hypnotics, induce relaxation and sleep. When taken in small doses, they reduce daily tension and anxiety. This group includes the barbiturates, the most widely abused among the depressants. When used without close supervision, the possibilities of taking increased amounts and becoming dependent are present. In street parlance, sedative-type depressants are called "goof balls" or "downers."

Milder forms of depressants are frequently termed "tranquilizers." These drugs calm, release and diminish anxiety. Like sedatives they may cause drowsiness. Tranquilizers that are used to treat serious mental disorders are not dependency producing. However, there are some tranquilizers like meprobate (Miltown, Equanil) to which dependence can be developed.

Depressants can become physically addicting. Tolerance to the effects of barbiturates develops and withdrawal symptoms occur when use of the drug is stopped. A strong desire to continue taking the drug is present after a few weeks on large amounts. Addiction to 50 or more sleeping pills a day has been reported. In addition to barbiturates there are other depressants which possess danger of addiction. Other addicting sedatives include glutethimide (Doriden), chloral hydrate and many others. In general, everything that is said about the barbiturates can also be applied to the non-barbiturate sedatives.

A major problem with all depressants is their synergistic effect when combined with other depressants. A combination of barbiturates and alcohol is a very common cause of death due to drug overdose. Prolonged use of depressants can impair judgment and intellectual performance.

Barbiturates and other depressants are generally abused by persons who have difficulty dealing with anxiety or who have trouble with insomnia. Barbiturates are taken by some heroin users either to supplement the heroin or substitute it. It is noted parenthetically that heroin is an extremely powerful depressant. Among many persons in the drug culture it is known as the "ultimate downer."

Biblical Reference To Herbs Superimposed
On Marihuana Leaf

A biblical reference to herbs is superimposed on a marihuana leaf. One is led to suppose that the use of marihuana is God's will and that legislation restricting such use is an affront to the divine.

Persons under excessive stress, or who can not tolerate ordinary stress, are vulnerable. Only a few years ago sedatives were drugs of abuse for adults. Now they are being consumed more and more frequently by teenagers and children in grammar schools. Persons who take amphetamines and become jittery are also common users of barbiturates.

6. *Other abuses.* There are many other drug abuses too numerous to mention. Children may sniff airplane glue, gasoline or other toxic vapors, for the dizzy reaction they receive. Most are unaware that such fumes are extremely poisonous and produce substantial brain damage.

There are constant new patterns of drug abuse in many bizarre areas. "Faddism" is rife among the nation's youth. The smoking of crushed banana peels, morning glory seeds, and other plant substances have been in vogue at various times during recent years. Incredible misuses of syringes have been reported. Substances such as peanut butter, coca cola and other food items have been injected by youthful drug experimenters.

Illegal Drug Traffic

A final major area of discussion with the federal authorities interviewed in Washington was an indepth analysis of illegal traffic in narcotics and dangerous drugs. This traffic both at the interstate and international levels is the preeminent concern of the Bureau of Narcotics and Dangerous Drugs. In the opinion of Assistant Director Tartaglino and other law enforcement representatives of the Bureau, illicit traffic in narcotics and dangerous drugs spans the globe, mirroring its effect in the soaring of drug abuse in this country.

1. *Illicit traffic in opiates.* There are two main currents of illicit traffic in opium and the opiates. One begins in the Middle East and ends in North America. The other pattern is from Southeast Asia directed to Hong Kong, Japan, China (Taiwan), and the West Coast of America. Secondary flows include routes from Mexico into the United States.

The North American Continent is the principal target of illicit heroin traffic. The bulk of this drug is produced from opium poppies grown in Turkey. The raw opium is converted into morphine base in clandestine laboratories close to the growing areas and then shipped through Istanbul and Beirut and smuggled into France to be processed into heroin. At this point, the heroin may be smuggled directly into the United States or transported through Italy, Canada or Mexico. It is, nevertheless, destined for the American market. Underground heroin trade from France generally involves large quantities of heroin smuggled by well-organized international traffickers who have contrived an extraordinary number of devious methods and devices to conceal the contraband.

In the Far East, opium is cultivated in vast quantities in the Yunnan province of China in the Shan and Kachin States in Burma. Although much is consumed by opium smokers in the region, considerable amounts of the drug find their way into the United States. In Burma and Thailand large quantities of opium are converted to morphine base and smuggled to Hong Kong and Macao for local use or diverted to the United States. In recent years an increasing demand for heroin by addicts in the Far East has somewhat decreased the supply available to American addicts.

Opium is also produced illegally in remote areas of Mexico by farmers who elude the government's poppy eradication program. It is con-

verted into heroin in clandestine laboratories and smuggled across the Mexican border in automobiles, baggage, on travelers, or in any of a thousand possible ways limited only by the smuggler's imagination.

2. *The marihuana market.* Although Near and Middle Eastern countries are a major center for production of the cannabis plant, from which marihuana is derived, most marihuana in the United States is originally grown in Mexico. Large quantities of marihuana, illegally cultivated in Mexico, are smuggled across the border into this country. This marihuana, as well as the Mexican heroin mentioned above, were the primary targets of Operation Eagle conducted by the Bureau of Narcotics and Dangerous Drugs in 1970 at various border crossing points of the Mexican-American border.

In addition to Mexican-grown pot, a recent influx of Vietnamese marihuana has been detected. This form of marihuana is considered to be more potent than that grown in South America. Occasionally, marihuana grown in the United States, including Illinois, is also found in the illicit traffic.

3. *Traffic in cocaine.* The cocaine traffic in the United States begins in the Andes Mountain regions of Bolivia, Chile, Peru, Columbia, and Ecuador where the coca leaf is grown. These leaves are processed into cocaine in clandestine laboratories and then smuggled into the United States through Miami and New York, often in airplane baggage or ship cargo.

One important pattern in this trade originates in Peru through Ecuador and Panama, then to Mexico and the United States. Another route starts in Chile, extends through Latin America to Pacific Coast ports and to the United States. A third route can be traced from Bolivia through Brazil to the West Indies and North America. According to BNDD authorities, traffic in cocaine has shown a tremendous increase during the past three years.

4. *Illegal traffic in dangerous drugs.* A large proportion of amphetamines and barbiturates in the illicit traffic is diverted from legal channels. A portion of illicit amphetamines and barbiturates is smuggled into the United States from Mexico. They may have been produced in secret Mexican laboratories or legitimately manufactured or diverted to Mexico from legally produced American stocks. Other portions of the American supply originate through theft and by production in clandestine laboratories, operating illegally in garages, basements, warehouses and other structures. Mobile laboratories in trucks have been known to exist. Some registered manufacturers, under the cloak of legality, make quantities of dangerous drugs unlawfully and dispose of them through the black market trade. The illegal "bulk" peddler who deals in hundreds of thousands of capsules is an important link in the traffic in dangerous drugs.

Since there is no legal production of hallucinogenic drugs in the United States, the criminal traffic depends on production from illicit laboratories, or smuggled drugs from Europe, Mexico, Canada, and Australia. In recent years there has been a proliferation of clandestine drug laboratories in many college and university towns across the nation. Since a minimum of chemical knowledge is required and since only a modest beginning budget is needed, these "student" laboratories have become a tremendous concern to both federal and state law enforcement agencies.

5. *Distribution and diversion.* Methods of distribution of narcotics and dangerous drugs are similar. Both are transfered from the major trafficker to the distributor, then to the street peddler and finally to the user.

Once the drugs reach the user, the cost has escalated. For example, the same 10 kilograms of raw opium grown in Turkey and sold to an underworld broker for $350 will produce nearly 45,000 packets of five per cent pure heroin worth $5 each, for a total of $225,000.

Pills are also profitable. Stimulants and depressants can be manufactured for approximately one-half to one cent each. On the black market, the going price is about 20 cents for a pill or capsule.

It is noted, however, that the price of any drug is totally dependent on the location of the user, demand for the drug, availability of the drug, and purity of the drug. For this reason, the street prices of virtually all drugs show great variance from city to city.

Most narcotic and dangerous drugs (with some exceptions such as heroin, marihuana and hallucinogenic drugs) are valuable medicines. Some drugs, such as those used for a headache and the common cold, can be sold over the counter. The more potent substances, including narcotics, amphetamines, and barbiturates, are, of course, required by law to be dispensed only with a physician's prescription.

Notwithstanding this safeguard, the drug abuser has found various ways to obtain his drugs illegally. He may alter the date and dosage of an existing prescription or forge a new one on a prescription blank stolen from a doctor. He may purchase his supply from a truck stop, news stand, bar, or retail peddler. He may even make arrangements with an unscrupulous pharmacist to purchase dangerous drugs without a prescription.

Drugs intended for medicinal use have been diverted into the illicit drug trade by dishonest plant employees, by overproduction and thefts from supplies in warehouses, hospital pharmacies and persons licensed to handle the drugs. These latter instances of diversion have long been a major concern of the Bureau of Narcotics and Dangerous Drugs. Special steps to curtail these diversions have been taken in the new Federal Drug Act.

Chapter 11
INTERVIEWS OF LOS ANGELES AUTHORITIES

Purpose

From November 29 through December 1, 1970 members of the Commission interviewed 10 authorities and their associates in the Los Angeles area.

Los Angeles ranks second to New York City in terms of metropolitan cities having the most serious drug problem in the United States, with Chicago ranking third. Therefore, it was logical that we study the situation in Los Angeles particularly those existing programs of drug treatment and rehabilitation to determine possible applications in Illinois. Authorities at various levels of government and those unconnected, but nationally recognized as drug experts, were included among the persons we consulted concerning the various disciplines that were the subjects of our Illinois study.

Daniel P. Casey

Mr. Daniel P. Casey is the Regional Director of the United States Bureau of Narcotics and Dangerous Drugs for the West Coast, headquartered in Los Angeles. Mr. Casey said that California is the hallucinogenic capitol of the world. He made particular reference to the area around San Francisco and Laguna Beach. Recent investigations have shown that psychedelic laboratories in the Bay Area supply London, Australia and most of the United States with hallucinogenic drugs such as LSD.

Mr. Casey reported that the United States can no longer complain that it is a drug "victim country." Because of the tremendous production of dangerous drugs, it has now become a "supplier country." Not all of the drugs being shipped out of the United States constitute illicit traffic. A tremendous volume of barbiturates and amphetamines are regularly exported for legal, medical and pharmaceutical purposes. A large percentage of these drugs, however, are frequently diverted into illegal channels of distribution and black marketeering in the destination countries. Because of this fact the new Federal Dangerous Substances Law,

which became effective May 1, 1971, permits the Attorney General to cut off the flow of drugs to foreign countries when shipments exceed the reasonable medical needs of those countries.

A similar problem exists in the United States with respect to the unchecked distribution of barbiturates and amphetamines for weight loss. So called "fat doctors" have made tremendous profits and caused substantial drug dependency through the unscrupulous prescription of weight reduction pills.

California is a major point of arrival for illicit marihuana and heroin. These latter drugs are processed in Mexico and shipped across the border into California at Tijuana.

Shipments such as these from Mexico have been a major source of investigation for federal drug authorities in Southern California for many years. Recently their efforts have been aided by Mexican authorities who have used federal soldiers and helicopters to detect marihuana farms. Similar Mexican efforts are underway in the search for illicit poppy farms. Mr. Casey noted that the Mexican heroin supply far exceeds the demand in California. Millions of dollars worth of heroin and marihuana cross the border each month in California without checks. Crossings are made on foot, in cars, on burros and in light planes which fly in under the radar screen.

Mr. Casey observed that it is impossible to seal off the Mexican border. This would cause tremendous disruption for tourists and commuters as well as diplomatic relations with Mexico. Since a sealing-off operation is impossible, the Federal Government must confine its efforts to selective investigations of major suppliers and occasional crack downs such as the 1969 "Operation Intercept" which netted tremendous quantities of marihuana from incoming motorists. Maneuvers, such as Operation Intercept, however, have the adverse affect of causing mammoth traffic tie-ups and frayed tempers. Another unfortunate result of such operations is the acceleration of prices on the domestic market because of the scarcity of drugs when supply lines are closed down.

Mr. Casey reported that the general drug scene in California is beginning to gravitate away from hallucinogenic drugs such as LSD. For the most part, he said that recent warnings of genetic disturbances and continuing psychotic reactions have caused many youths to seek out other drugs which do not have these harmful side effects. Unfortunately, however, the illicit manufacturers are quick to respond to this fear and now mislead drug buyers into believing that they are receiving organic drugs, such as mescaline, when in fact they are receiving the very same hallucinogens that they sought to avoid.

Mr. Casey said that the number of clandestine laboratories is proliferating wildly. Psychedelic drugs can be manufactured with virtually no knowledge of chemistry. A highly productive laboratory can be set up for under $1,000.

Mildred Klein

Mrs. Mildred Klein is a Narcotics Consultant to the Community Relations Division of the Los Angeles County Probation Department. She has spent the greater part of her career dealing with drug addicts.

Mrs. Klein stated that there is a great need for independent analysis of the extent and nature of the individual subject's pattern of drug abuse. Her experience has shown that broad generalities about drug abusers are frequently inaccurate since the individual motivations which cause a person to turn to drugs are as varied as the human experience itself.

Mrs. Klein said, however, that some broad categories can be established. The first group would include "criminals who use drugs." This would include career criminals, such as thieves, who have drug habits which are unassociated with their criminal conduct. A second category would include drug abusers who have turned to crime for support of their habit. In this category you find the familiar addict who can not support his drug needs on his salary and must turn to larceny and other crimes in order to obtain the necessary funds to support his addiction. The third category would include drug abusers who have no criminal patterns whatsoever. Examples of this category include the youthful marihuana smoker and the drug dependent housewife. It was Mrs. Klein's conclusion that members of this third category should not be included in ordinary criminal correction programs. Instead, they should be treated as a "human-environmental-community" problem.

Mrs. Klein insisted that each drug abuse case which comes to the attention of the authorities should be individually analyzed. She noted that some abusers may have a psychological prob-

lem, some may have a medical problem, some may constitute basic criminal types, while still others may be involved with drugs for purely cultural and social reasons.

In Mrs. Klein's opinion, just as the reasons for drug abuse vary, so should the forms of treatment. In this regard Mrs. Klein pointed to the recent success enjoyed in California by the Teen Challenge Program. This treatment modality has a religious orientation. The members of the program believe that through prayer and devotion to Christian works, the "Spirit of the Lord comes to cleanse them of drugs."

Mrs. Klein reports that this treatment method has been very effective with young Christian adults at the high school level. Different forms of religious treatment have proven to be more successful with college level youths who oppose traditional western religions. Tremendous inroads have been made in California by Eastern mystics such as the late Maharishi Meher Baba. This religious approach, which is essentially Hindu, states that any use of drugs represents a pollution of the body, that this is not in keeping with God's design and is therefore wrong. Adherents to these Eastern beliefs frequently turn to forms of meditation and exercise which involve contemplation of the majesty of God. Trance-like experiences are encountered which the former drug users extol as a new "high."

Another form of treatment mentioned by Mrs. Klein is the Synanon concept of confrontation. Under this method, drug abusers are taught to reject drug abuse as symptomatic of irresponsibility and childlishness. Group therapy sessions are held which involve severe attacks on one's ego. Examples of a modified Synanon approach can be seen in Gateway House in Chicago and Daytop Village in New York City. This treatment form has had considerable success with urban Americans. It has encountered a peculiar lack of success in the case of Mexican-Americans.

Mrs. Klein underscored the need for public education. She suggested that the public needs to be informed not only about the drugs themselves but about people who abuse drugs. She regards it as important for society to come to view drug abuse in the same way it does alcoholism.

Legislatively, it was Mrs. Klein's chief recommendation that the laws should seek to divert non-criminal users away from the criminal justice correctional system. In addition to various community treatment programs, Mrs. Klein also expressed high regard for methadone maintenance programs.

Edward M. Davis

Edward M. Davis is the Chief of Police of the city of Los Angeles. He said that in just 10 short years his department's man power commitment to drug control had increased several fold. In addition to traditional methods of law enforcement his department has recently expanded into educational programs designed to teach the public about the harmful effects of drugs.

It was Chief Davis' conclusion that the current pattern of drug abuse in Los Angeles would soon be the case in Chicago. He remarked that California and Illinois, along with the rest of the nation, are in the midst of a drug abuse crisis. He noted that the crisis has existed in Los Angeles since approximately 1964. Drug abuse became socially acceptable in Los Angeles not only in the ghettos but in the suburbs and other middle class areas of the city.

In addition to the growing acceptance there was also a corresponding proliferation in the types of drugs used. As an example the Chief cited the onslaught of the psychedelic drugs and hashish, an oriental form of marihuana, which had been relatively rare in California prior to the mid-1960's.

Peter J. Pitchess

Mr. Peter J. Pitchess is the Sheriff of Los Angeles County. He has the largest sheriff's office in the nation.

Sheriff Pitchess, like Chief Davis, underscored the importance of education in the total law enforcement approach to drug abuse. He said that drug education should begin in kindergarten and continue through the 12th grade. He cited the sixth and seventh grades as critical in dissuading modern youths from joining the "drug scene". He noted that children today can no longer be "shocked" out of drug abuse. For the most part they are too sophisticated for "scare tactics". He suggested that there is a tremendous need for peer group pressure to convince children not to experiment with drugs.

In the treatment aspect of drug abuse he is of the opinion that "self help" groups have been the most productive in turning the drug abuser away from dependency. He suggested that the

evangelistic spirit shown by members of Teen Challenge and Synanon might be of assistance in formulating an effective drug education program.

Sheriff Pitchess also expressed alarm over the recent proliferation in the types of drugs being used. He cited recent statistics accumulated by his department which showed that, on a percentage basis, cocaine was the fastest rising drug of abuse. Cocaine has mild aphrodisiac qualities. It has frequently been linked to the growing interest in group sex and other forms of sexual promiscuity which are fast becoming culturally acceptable in Southern California.

Joseph P. Busch

Mr. Joseph P. Busch, Jr. is the newly appointed District Attorney of Los Angeles County. The Commission met with Mr. Busch and his associate, Assistant District Attorney John E. Howard.

Mr. Busch stated that narcotic violations represent about one half of the District Attorney's case load in Los Angeles County. The majority of defendants are young adults and teenagers. A large percentage of these are transient youths who have been attracted by the glamor of Los Angeles.

The District Attorney's Office has experimented over the past two years with educational programs which are sometimes offered in lieu of a sentence. This is particularly true of marihuana possession cases. Under a California law possession of marihuana is a "reducible felony". That is, the trial judge may reclassify the particular violation as a misdemeanor given extenuating circumstances. Many of these defendants have been sent to education programs in lieu of a jail term. Mr. Howard reported only moderate success with this program since many of the youths are very closed minded and regard "education" as nothing more than government propaganda.

Roland W. Wood

Mr. Roland W. Wood is the Superintendent of the California Rehabilitation Center, Department of Corrections, Corona, California.

The California Rehabilitation Center at Corona is a minimum security narcotics prison located 50 miles East of Los Angeles. The facility represents a middle ground between a pure "treatment" approach versus a pure punitive or correctional approach. Although a very obvious prison atmosphere is present, numerous programs exist of a rehabilitative nature. These programs are designed to recycle the drug addict into society.

It is the view of the correction officials at Corona that more control than is necessary for convicted drug abusers is nothing but punishment; less control than is necessary is poor treatment.

The California Rehabilitation Center was created in September, 1961, as a treatment institution to administer California's civil commitment program. The program provides compulsory in-patient and after-care treatment and control for opiate users.

Addicts are civilly committed, rather than sentenced, by the superior courts of California. The civil proceedings under which the addict may be committed can be initiated in three ways:

(1) The addict, a relative, or some other responsible person may approach the County District Attorney, who may then petition the court for consideration of the addict's commitment. No criminal charge is involved.

(2) If any person is convicted of any crime in a municipal court and is believed by the judge to be an addict, the proceedings may be adjourned or the judge may suspend the imposition of sentences in deference to a voluntary civil commitment.

(3) Any person convicted of a felony (with certain exclusions for aggressive offenses) may, if the judge believes he is an addict, be referred to another superior court to determine the issue of his addiction after he is convicted and the original criminal proceedings are suspended.

The commitment proceedings are essentially those used for commitment of the mentally ill. The statutes provide that the addict be informed of his rights, be examined by two medical doctors, be permitted to produce witnesses in his behalf, be personally present in open court and have counsel. If he is dissatisfied with the commitment order of the court, he may demand a jury trial on the issue of his addiction.

Whether referred by the criminal court or without a criminal charge, all commitments are for the same legal and technical reason: addiction or "imminent danger" of addiction. The

Some head supplies are not used in connection with the actual administration of drugs. Instead, they are simply used to evangelize or extol drugs. A green marihuana leaf superimposed on a red star becomes an arm patch supporting drug usage.

criminal charge, if any, is irrelevant, since it remains in suspended status with the court.

Once he is committed, the addict is bound for a definite period even though he may have initially volunteered for treatment.

The law provides a maximum two and one-half year commitment for volunteers and a seven year commitment for others. This term includes both in-patient care and after care, thus allowing for several returns to the Center for additional treatment if needed.

The law requires a minimum of six months in-patient treatment on his original commitment but sets no limit on length of stay for a returnee.

In-patient care consists of intensive group action in community living groups, small group work, academic and vocational instruction, recreation, work therapy, physical fitness, and relations programs. Staff members work closely with inmates who are housed in dormitory like settings. Extensive use of group therapy is made on the assumption that "there is therapeutic energy available within the delinquently oriented peer group."

The basic treatment unit is referred to as a "therapeutic community". Each hall is composed of 60 inmates, a Correctional Counselor and a Correctional Officer. These two staff members, supported by another who acts as a consultant, meet with all 60 inmates for approximately 45 minutes, five days a week to discuss their problems.

Release is based upon the resident's effort and progress. When the institutional staff says

that the resident has made sufficient progress to leave the Center, he is certified by the Superintendent to the Narcotic Addict Evaluation Authority, a four member board appointed by the Governor vested with releasing, returning and discharging authority.

The median length for in-patient stay for original commitments is under one year; for returnees, from six to nine months. Commitments can be returned to court as unsuitable for treatment after 60 days of evaluation and observation in the program.

When transferred to the state-wide out-patient program, the releasee enters a 30 man case load and is supervised by a specially trained field agent who works only with releasees from the Center. The out-patient program offers close but supportive supervision, small case loads, anti-narcotic testing, group therapy, limited out-patient psychiatric care, job placement assistance, and halfway houses. If the releasee abstains from the use of narcotics for three consecutive years, he may be discharged from his commitment and the criminal charges against him, if any, may be dismissed by the judge.

It should be noted that most of the drug authorities consulted during the California tour were critical of the Corona facility. In general, the Center was criticized for its "over-emphasis of correctional methadology." It was reported that because of the prison-like atmosphere of the Center substantial resistance had been exhibited by inmates. Moreover, because of the correctional atmosphere at Corona, it has experienced many of the problems that prisons generally have experienced. These would include homosexuality, resistance to authority, and further retrenchment of criminal patterns of behavior. It was interesting to note that virtually all personnel encountered at the facility came from correctional, rather than treatment, backgrounds.

Edward C. Boyle

Mr. Edward C. Boyle is affiliated with the Salvation Army Family Service Center in Los Angeles, California. He has worked with drug users in residential treatment centers in the community. He is the founder and Director of the Manhattan Project. Mr. Boyle has been on numerous local, state, and national drug and crime commissions.

Mr. Boyle said that the drug problem became critical in California in 1963. At that time adequate treatment practices and facilities had not been developed. As a consequence, many youthful drug offenders were being incarcerated rather than treated. He suggested that these youths had different personality structures than adult addicts. Moreover, they did not exhibit any criminal conduct other than their dealings with drugs.

Because of this situation, Mr. Boyle founded the Manhattan Project. This is a community based program designed to keep the youthful drug abuser out of the state's jails and prisons. The basic tenet of the program is that young persons stand a much greater chance of rehabilitation in their own communities than they do in correctional facilities.

It is the goal of the Manhattan Project to place young drug abusers back into their schools and their families without being scarred socially by the mere fact of their drug experimentation.

Young persons who undergo Mr. Boyle's treatment maintain their residences at home. This "non-residence status" avoids the idea of creating "islands" for drug users. The emphasis is on normal day to day functions. Segregation and isolation from the community at large is carefully avoided.

It has been Mr. Boyle's experience that most California youthful drug abusers have exhibited a nomadic pattern of non-involvement with the community. They have no stability or roots. Before long virtually all of their associates are fellow drug users. In many cases their reason for turning to drugs is a rejection of the impersonalized society in which they live and a reaction to the lack of identity which they have experienced in that society.

Mr. Boyle has concluded that this general phenomenon has given rise to a youthful drug culture in California. An entire generation of young persons has commenced a search for a "youth-identity." Members of this drug culture all across the nation have drawn together anything which is peculiarly identified with youth. This youth "bag" includes rock music, bizarre clothes and drugs. Additionally, there is a pervasive morality present. It includes a rejection of the Protestant ethic regarding sex, cleanliness, frugality, and the will to succeed. The increased manifestation of this youthful drug culture was seen at the Woodstock, New York, Festival in upstate New York in August of 1969.

Mr. Boyle's project makes use of extensive counseling services which are designed to blend with the life styles and general backgrounds of the youthful drug abusers. In fact, the only change the Manhattan Project seeks to make is a turning away from drugs and a desire for compatability with the community at large.

Mr. Boyle is strongly opposed to probation services which are oriented to the view that youthful drug users are criminals. He favors ambulatory community drug treatment centers wherever possible. In those instances where incarceration is absolutely necessary, he favors civil commitment.

Eduardo Aguirre

Mr. Aguirre is the Director of the League of United Citizens to Help Addicts in Los Angeles. This organization, of which he is the founder and director, has placed former drug users and ex-convicts in jobs. He is also involved in submitting proposals for changes in legislation regarding drug users and addiction. He recently wrote *The People's Proposal,* a document setting forth views regarding needed changes in legislation and treatment programs for drug addicts.

Mr. Aguirre first thought of establishing the League of United Citizens while he was imprisoned on a drug conviction in San Quentin Prison. It was his goal to transfer all addicts from the criminal justice system to the "socio-medical system."

As it exists today, the League of United Citizens is basically a job placement center used by former addicts who desire employment after they completed the withdrawal process.

Among the suggestions made in the *People's Resolution* is the proposal that the parole provisions for addicts should be revamped to remove the criminal stigma attached to drug abuse and to facilitate their return to normal unencumbered community life styles.

Mr. Aguirre suggested that unless this change is made, the nation will continue to experience the problem of "revolving door criminal addicts." In his opinion this class of persons is created by unrealistic sentencing procedures supplemented by oppressive parole requirements. Mr. Aguirre deplored the practice of parole officers attempting to secure information from parolees regarding addicts in the community. He was extremely critical of the nalline test for opiate addiction. Although this practice has been abandoned in Illinois, it still exists in California. The test involves the injection of a nalline solution into the subject's arm. If the subject has recently used an opiate, a physiological reaction will quickly occur. According to Mr. Aguirre people subjected to nalline become very "grouchy" and sometimes can be reintroduced to drug addiction through their enjoyment of the injection itself. He suggested that urinalysis is a far better test of addiction for parolees.

H. Bruce Baumeister

Mr. H. Bruce Baumeister and his associate, Mr. Roy Dankman, are the President and President Elect, respectively, of the Association of Juvenile Court Lawyers. Mr. Baumeister was recommended to the Commission by show business personality Art Linkletter as a "brilliant local (Los Angeles) attorney who heads up a group of some 25, like-professionals, who volunteer their legal services to young people hauled into court on first drug offenses."

Mr. Baumeister explained that his association began in response to the tremendous loss of court time suffered in Los Angeles County in marihuana cases. It is the hope of the association that marihuana possession cases will eventually be removed from prosecutions involving dangerous drugs and narcotics. Mr. Baumeister noted that marihuana is an extremely mild drug by comparison and that its users represent a totally different type of offender than that usually associated with the "hard drugs."

Mr. Baumeister drew an analogy between an arrest for possession of marihuana and a serious moving hazardous traffic violation. He questioned the rationality of a legal system which is more opprobrious of the simple marihuana user as compared to the hazardous driver. He noted that in California a marihuana arrest is much more deleterious to one's future than a moving hazardous violation.

Mr. Baumeister was very critical of California's failure to draw a distinction between the ordinary drug sale and the "accommodation" sale. This latter sale involves the transfer of a relatively small quantity of drugs to a friend or associate of the seller without profit. The typical example of an accommodation sale cited by Mr. Baumeister is the sale of a small amount of marihuana by a college student to his roommate at the same price he paid.

Mr. Baumeister suggested that until substantial research is done to prove the harmfulness of marihuana, its simple use or accommodation sale should not be classed as a felony. Severe marihuana penalties should be reserved only for the sellers of large quantities. Minimum mandatory sentences should be reserved for professional traffickers. In all other cases judges should be given absolute discretion in the area of minimum sentencing.

Dr. Edward R. Bloomquist

Dr. Edward R. Bloomquist is an associate Clinical Professor of Surgery (anesthesiology) at the University of Southern California School of Medicine at Los Angeles. He is a world renowned expert in the area of narcotics and addiction. His book *Marihuana* is one of the best known in the field.

According to Dr. Bloomquist marihuana has become more than a mere drug. It has become an ideological symbol to much of American youth. He said it is unfortunate that it has become classed with other drugs for purposes of criminal penalties. It is pharmacologically inaccurate and "reprehensible to the many youths who stand in defense of the drug." Although Dr. Bloomquist believes that marihuana has been misclassified and that the penalties are generally far too severe, he does not believe that marihuana should be legalized. To the contrary, he has been a leading voice in showing the many harmful effects of marihuana. According to Bloomquist, marihuana is an "apathy promoting drug." That is, when used on a heavy regular basis the drug has been shown to dull one's normal desires to inquire, to succeed and advance in terms of position and responsibility. Indeed this apathy-promoting quality in many cases has blended with the "anti-establishment" philosophies of its users.

Dr. Bloomquist noted that except for users who have artistic inclinations, research has shown that most heavy marihuana users have experienced "bad trips" on one or more occasions. The novice smoker will have a tendency to resist when he or she first experiences the peculiar sensations and hallucinations brought on by deep marihuana ingestion. The logical outcome of this resistance is panic followed by "something approaching a mild psychotic episode."

Dr. Bloomquist rejects the constant comparisons between alcohol and marihuana espoused by those who favor the legalization of cannabis. He said that both are drugs but in no way comparable. Moreover, the fact that the effects of alcohol have been shown to be so disastrous in terms of loss of health, life, and property is not a convincing rationale for the legalization of a drug which is *at least* as harmful. If one chooses to compare the "high-producing" effects of the two drugs, alcohol is a very poor second. One "joint" of average quality marihuana is comparable to four very dry martinis. Lastly, the generally accepted purpose for imbibing alcohol is that of relaxation and sociability. According to Dr. Bloomquist, the whole idea of using marihuana is to get *"high."*

In this latter regard Dr. Bloomquist went on to suggest that "the whole point of marihuana is to distort reality. The distortion is brighter and intensely more pleasurable than reality. The come down is highly unsatisfactory. To the frequent user life without marihuana is like a Christmas tree after the lights have gone out." These pleasurable distortions of reality in part explain the reason why constant marihuana users are so evangelistic in defending their habits.

Dr. Bloomquist also cited historical arguments in arguing against the legalization of Cannabis Sativa L. Using the examples of India, Nigeria, China and Formosa, Dr. Bloomquist showed that these countries did not begin to move toward an industrialized modern society until they had outlawed marihuana. Bloomquist noted that "once you legalize marihuana you have cut your throat, you can hardly now tell millions of cannabis dependent users that marihuana is bad."

Dr. Bloomquist recommended that cannabis violations should statutorily be classed as separate offenses. In his view, marihuana is a unique drug with a peculiar class of users and cannot be categorized with the hard drugs such as heroin and speed.

Dr. Bloomquist has supported suggested reforms in sentencing whereby the convicted marihuana defendant would be channeled away from the criminal justice system. In his opinion, incarceration of the marihuana offender succeeds only in criminalizing the person and increasing his fervor for the use of marihuana. He agreed with a suggestion made by Co-Chairman Henry J. Hyde that marihuana offenses could be compared with traffic violations in terms of penalties. That is, the case could be continued while the first offender receives instruction on the harmful effects of marihuana and drug abuse in general.

Dr. Bloomquist made several remarks generally about the changing aspects of drug abuse in California. He noted that in recent years promiscuous sexual conduct has been incorporated into the life styles of many drug users. He suggested that this is a logical extension of the new generation's relaxed views towards sex generally. In the area of marihuana he stated that it relaxes sexual inhibitions, increases suggestibility and enhances the sex act itself. The problem, however, arises as there is increased dependency on marihuana in order to achieve sexual arousal. Several clinical studies have shown that prolonged sexual dependence on marihuana has produced virtual impotence in young, otherwise virile, men. Other drugs have become popular in California because of their sexual properties. Amyl nitrate, xylocaine and cocaine have all seen rapid escalation on the illicit drug market. These drugs are used as local anesthetics in the sex act to produce prolonged activity and more intense satisfaction.

In the area of dangerous drugs other than the opiates, Dr. Bloomquist stated that the chief problem was that of over-production. He called for state regulations to control the manufacture of amphetamines and barbiturates. He noted that the opiates are erroneously thought of as the most toxic of drugs. He noted, for example, that "speed" (methamphetamine) is the most disastrous of all drugs. He suggested that any legislative program should be created to organize these various levels of toxicity.

Chapter 12
INTERVIEWS OF SAN FRANCISCO AUTHORITIES

Purpose

The Commission interviewed 10 authorities and their associates in the San Francisco area on December 3 and 4, 1970.

We received valuable input from them regarding federal and local law enforcement programs, private rehabilitation and treatment programs, the marihuana problem, methadone treatment, and other important areas.

Alfred Nelder

Mr. Alfred Nelder is the Chief of Police of San Francisco. His city has seen an alarming increase in drug abuse over the past eight years. The major problems are psychedelics and other dangerous drugs in the Haight Ashbury Area and opiate addiction in the ghetto and Chinatown area. Since his recent elevation to chief of police, he has enlarged his narcotic division substantially and has greatly broadened its approach in combating the problem of drug abuse in San Francisco (see following summary).

Chief Nelder blamed the recent proliferation of drug abuse in San Francisco on what he termed "rampant permissiveness." He called for increased penalties against drug sellers and manufacturers and decreased penalties for drug users particularly in the case of first offenders and users of milder drugs such as marihuana.

Herbert Lee

Inspector Herbert Lee is an officer in the San Francisco Police Department Narcotics Division. He is in charge of that division's grade school drug education project. He is known affectionately to his students as "Little Herbie." He informs fourth, fifth, and sixth graders about the ravages of drug abuse.

Inspector Lee displayed visual aids and went through his presentation for the benefit of the Commission. In addition to explaining what the various drugs look like and their physiological effects, Inspector Lee acted out situations with the children. In these situations Lee plays the

role of a drug pusher on the street. He attempts to coax the children into accepting the drugs after he has explained their harmful effects. Invariably the child tells him, "No, Herbie. Pills are bad for you."

It is important to note that Inspector Lee delivers these addresses while attired in his police uniform. In his opinion this instills faith and credibility in the police department and enhances the child's trust in the individual police officer.

Inspector Lee displayed dozens of letters from children thanking him for telling them about drug abuse. He suggested that it is never too early to begin drug abuse education; even to the point of beginning in kindergarten.

Dr. George Gay

Dr. George Gay, M.D., is the Chief of the Drug Detoxification Center and Director of the Heroin Clinic at the Haight Ashbury Medical Clinic in San Francisco. The Commission met with Dr. Gay and several of his associates at the Haight Ashbury Clinic.

The Haight Ashbury section of San Francisco is a depressed economic area of that city which has provided a magnetism for radical thinkers, society dropouts, drug abusers and "flower children" since the mid-1960's. The rapid growth of Haight Ashbury closely paralleled the spread of the drug revolution which began in about 1965.

This area has traditionally been the center of America's youth drug subculture. New drug patterns are established in Haight Ashbury and then tend to "ripple" out and involve other parts of the country. According to clinic staff members, the Haight Ashbury drug user is, therefore, 6 to 18 months ahead of his counterpart elsewhere in the country. It is expected that the pattern will repeat itself with heroin usage. Other parts of the United States including Chicago are already reporting the beginnings of increased heroin addiction among middle class white youth.

At one time the district was the scene of peaceful young people who wore bizarre clothing and used the district as a "city within a city." Today most of the flower children and utopian thinkers have fled Haight Ashbury and now live in communes throughout California and neighboring states. Those who have remained in the area represent the disillusioned aftermath of an era of optimism.

Although drug abuse had been a common phenomenon for Haight Ashbury since its inception, addiction began to be a problem in the early part of 1967. The heroin addicts in Haight Ashbury represent a new type of addict. Heroin, because of its strong tranquilizing and analgesic qualities, has traditionally been used as a drug of escape. The major segment of our population which has traditionally sought this escape has been that of the non-white ghetto. In Haight Ashbury during the past several years there has evolved a new style of heroin addict consisting largely of alienated white youth suffering from disillusionment, disaffiliation, frustration, and despair. These young people began turning to heroin abuse as the most effective escape mechanism available to them.

Since its inception in 1967, the Haight Ashbury Medical Clinic has provided the primary source of general health care for these people. In response to the growing number of patients suffering with symptoms of heroin withdrawal, the clinic opened a special section devoted exclusively to drug detoxification on an out-patient basis. It continues to be the policy of the Haight Ashbury Medical Clinic to administer all treatment free of charge to all who apply. According to Dr. Gay the Clinic employs no screening or other traditional social service devices designed to discourage utilization of the program by the past.

On their initial visit, each patient is asked a series of questions by a clinic staff member regarding his social situation and drug usage. The answers are recorded and become a permanent part of each patient's medical record.

After this entrance interview the addict receives a general medical diagnosis. Because heroin is an analgesic with pain killing properties even greater than morphine, incoming addicts are frequently suffering from numerous maladies of which they are unaware. Most are in need of substantial dental work. Others may be suffering from illnesses ranging from bleeding ulcers to appendicitis. Cases of malnutrition and extreme vitamin deficiency are also common.

The patient decides for himself what method of withdrawal he will use. Approximaetly one half of the addicts choose to withdraw by total abstinence. This method is commonly referred to as "cold turkey." About 20 per cent choose to withdraw through the use of methadone. Those remaining go through withdrawal under specialized medications administered by a physician.

Following withdrawal and medical treatment the patient is introduced to an ambulatory treatment program. The patient continues to reside in the community but reports to the clinic at regular intervals for therapy sessions. According to clinic staff members the broad advantages of out-patient (as opposed to institutionalized) therapy are:

(1.) Closer contact with the patient as a real person, enabling the staff to relate on an individual rather than a stereotyped basis.

(2.) More freedom for the patient whose actions now tend to be helf-regulated, rather than those of directed rationalization under the pressure of programmed requirements.

(3.) A higher likelihood of discovering positive and creative therapist-addict relationships than would be likely in a setting influenced by traditional attitudes.

Dr. Gay reports that 56 per cent of clinic patients have dropped out of the program; that is they have disappeared before staff members felt they were "clean", and have been lost to follow-up for two weeks or more. Five per cent are known to have resumed their habit. About 22 per cent of those who abandoned the program eventually return for a second try.

Daniel J. Addario

Mr. Daniel J. Addario is the Special Agent in Charge of the United States Bureau of Narcotics and Dangerous Drugs Office in San Francisco, California. According to Mr. Addario, since 1966 San Francisco has been a drug barometer for drug abuse patterns throughout the United States. He said that these patterns have foreshadowed a similar shifting drug preference throughout the country by 6-30 months. Mr. Addario noted that his office's chief problems involve the tremendous increase of illicit laboratories throughout the Bay Area as well as the alarming increase in heroin traffic in San Francisco.

Perhaps more than any other community in the nation, San Francisco has had the greatest problem with the psychedelic drugs. These drugs are capable of provoking changes of sensation, thinking, self-awareness and emotion. Mr. Addario reported that although medical warnings concerning LSD had some initial effect in reducing usage, illicit manufacturers were quick to circumvent the new threat to their business. They have now simply changed the form and color of their drug products. They then unscrupulously sell the very same drugs such as LSD, DMT, STP, and dozens of others as milder drugs such as mescaline.

Mr. Addario agreed with the staff members at Haight Ashbury who said that the recent increase in heroin addiction among white middle class youths was a product of their disillusionment and despair. He suggested that another reason for this growing addiction rate may be due to the fact that heroin is regarded as the "ultimate downer." "Downer" is the drug user's word for any drug that produces a sedative effect. Heroin is, perhaps, the strongest sedative available to the addict; hence the term "ultimate downer." Mr. Addario suggested that many young persons who are suffering the horrifying experience of speed and other, wildly active stimulants, will turn to heroin in an effort to "come down" from the frightening sensations of their "bad trips."

Richard G. Christensen

Mr. Christensen is the Director of the Creative Life Foundation in Seattle, Washington. He travelled to San Francisco to meet with the Commission members on the recommendation of Mr. Art Linkletter, who praised his outstanding work in teaching parents and other adults about the drug problem.

According to Mr. Christensen it is the purpose of the Creative Life Foundaton, "to build a bridge of understanding between individuals using the modern tools of communication to understand drug abuse." The Foundation was created by Mr. Christensen in 1968. Mr. Christensen has been the Chaplain for the Seattle Police Department since 1966. While associated with that department he began to see first hand the pervasive drug culture in Seattle and the extent to which it was damaging the youth. He told the Commission that while he was achieving results in his work with young people, he was continually amazed, frustrated, and disappointed in dealing with the parents of children with drug problems.

He said that not only were the parents ignorant of their children's drug problems and solutions, but they were often totally unable to talk to their children. It was this situation, he concluded, that was the root of the problem. For, according to Mr. Christensen, without communication, there is little transfer of love, understanding and responsibility between the parent and child. Without these ingredients the child is unprepared and unable to resist the many temptations offered by his peer group.

Acting on these principles Mr. Christensen established his program to train adults to deal with the massive drug problem in the home, on the campus, and in industry. Adults are trained as referral sources for the community to assist probation officers, school counselors, teachers, clergy and concerned laymen.

In addition to teaching about all aspects of drugs and drug usage Mr. Christensen has sought to convince his listeners that the only way to reverse a youthful drug culture is to establish a replacement which is attractive to the young. In this area Mr. Christensen has sought to engender a totally new anti-drug culture with its own music, art forms, clothes, and food.

It is Mr. Christensen's hope that an informed adult population and a charismatic anti-drug youth culture are necessary prerequisites to the eventual eradication of drug abuse among the young.

Gordon McLean

Mr. Gordon McLean is the co-author of the recent best selling book, *High on the Campus*, and is the Executive Director of Drug Abuse Information Service, a teenage rehabilitation center in San Jose, California.

It is Mr. McLean's opinion that the most important weapon in attacking drug abuse is the dissemination of understandable, accurate information about drugs and their patterns of abuse. Mr. McLean noted that California has experienced a 2,000 per cent increase in juvenile drug arrests over the past 6 years. He estimated that at least 30 per cent of California high school students have experimented with some form of drugs. He suggested that for every juvenile arrested, it is safe to estimate that there are 30 to 50 who do not come to the attention of authorities. He said that Los Angeles officials have estimated that $250,000 is spent every day on illegal drugs in their city alone.

Mr. McLean said that parents, particularly, are concerned, anxious, and "just plain scared." For most students, the use of drugs is only an occasional event. For others, McLean said, "it has become a way of life, because the experimenting can't, at least for them, be limited." He said that these young people happen to be susceptible to certain drugs, become dependent, and get badly hurt from what may have started out as an innocent adventure.

Complicating the problem, according to Mr. McLean, is the fact that we live in a drug oriented society. He stated that new alcoholics are produced in this nation at the rate of 50 an hour. He further noted that "millions of people are addicted to cigarettes, though they usually insist they can quit at any time." Truck drivers and students cramming for a test often will take pep pills to keep them awake, or persuade doctors to give them diet pills to lose weight.

POT RELIEVES TENSION

Although generally true that marihuana acts as a tranquilizer, medical research has shown that the opposite reaction can be generated in some persons.

Mr. McLean is of the opinion that drugs have become a way of life for a vast number of adults in the United States. They take pep pills to get up, tranquilizers to stay calm, a cocktail to start the evening, and a barbiturate to go to sleep. He suggested that this pattern makes for a "very short day for rational thinking."

In his opinion the young are also influenced by a growing number of movies and songs glorifying the use of drugs. Through their music and in pictures, "the cool generation is telling the squares what is happening." He agreed that the use of drug terms in modern music does not mean that young persons are going to be influenced to take drugs. But he warned that the "trend towards drug promotion

and vulgarity in music is not a healthy one. Dirty words used to be scrawled on walls; now they're flashed on screens or on 'top-forty' records."

Dr. Seymour M. Farber

Dr. Farber is the Dean of Continuing Education in Health Science at the University of California Medical Center in San Francisco. The Commission met with Dr. Farber and his assistant, Mr. John Luce. Dr. Farber and Mr. Luce administer the Diane Linkletter Foundation. Together they are involved in a tremendous number of activities bearing on the medical aspects and information aspects of drug abuse among the young.

Dr. Farber and Mr. Luce underscored the tremendous importance of drug education in grammar schools. They suggested that particular emphasis should be given on the effects of drugs. In their opinion the most critical grades are the fourth through the sixth.

In their view effective peer group pressure against drug abuse can only be created if grade school youths are adequately supplied with accurate drug information before reaching their teen years. They suggested that adolescents are constantly in search of a "parent-family surrogate." This search is triggered, in their opinion, by this "rootless society" in which we live. These young persons search for meaning and direction in their every day lives. If they believe that the use of drugs is safe and desirable they will join the youthful drug culture without the slightest moment's consideration.

Dr. Farber and Mr. Luce gave eight reasons for drug involvement by young persons: First, there is the monotony of living. Each day in a young person's life differs very little from the preceding day. In the face of this monotony, a wild trip on drugs offers forbidden excitement.

Second is the many worries and imaginings of a young person. To the youth who worries about the future, about grades, about what people are thinking or saying about him or her, drugs become a reassuring "lollipop" to suck on, a "security blanket" to curl up with.

Third is the desire of many youths to shock their parents. Taking drugs is an outward rejection of society in general. Dr. Farber suggested that, "it's fun for them to see their parents being put on. Drugs give them something with which to get their parents enraged and incensed."

Fourth is a simple desire to escape tension. The "gigantic pressure cooker" in which most high schoolers find themselves is simply "too much" for many. The demands for high grades, heavy participation and the necessity of being a "social swinger" cause many youths to use drugs as a way out.

A fifth causation is mere curiosity. Dr. Farber's experience has shown that about one third of teenagers who experiment with drugs do so out of curiosity. He said that with all the talk going on about drugs the desire to "try some and see" becomes tragically strong for some otherwise level-headed young adults.

Another reason is a feeling of despair. Mr. Luce told the Commission that if one looks into the thoughts and feelings of students he will find that they consider themselves as "nothing much", and that their clumsiness or their overweight or their low grades or their rejection by other students keeps them from feeling self-assured. They may quickly cluster with other students who also feel that they are not "making it"—but that they can all get some "high and good" feelings through drugs.

A seventh reason is the false belief that drugs will aid in achieving one's "true potential." Like many of their predecessors, a great number of hostile, confused and inept youngsters seek instant transformation by drugs. All they need, they believe, is to swallow the magic potion and their true value will be revealed to a humbled world.

Lastly, there is the belief that drugs will somehow help the user to find a new "religious experience." In such cases the young abuser confuses the mind altering effects of drugs with divine revelations.

As noted previously, Dr. Farber and Mr. Luce believe that society's most effective countermeasures against these premises is a thoughtful, effective program of education and public information.

Dr. D. Harvey Powelson

Dr. D. Harvey Powelson is the Chief of the Psychiatric Clinic at the Cowell Memorial Hospital at the University of California at Berkeley. Five years ago Dr. Powelson was an advocate of legalizing marihuana. At the time he was a close associate of Dr. Timothy Leary, the well known exponent of LSD. Since that time the use of marihuana on the Berkeley campus and nationally has increased at an explosive rate.

It was Dr. Powelson's guess that more than 50 per cent of the students on his campus used marihuana at least occasionally.

Dr. Powelson informed the Commission that after five years of intense research he has reversed his earlier position regarding the legalization of marihuana. He said that in his job as Chief Psychiatrist he has had an unusual opportunity to observe the effects of marihuana on a great number of people in a great number of contrasts. In addition, he has had the task of thinking about his findings and correlating them with available scientific data. It is now Dr. Powelson's judgment, based on these five years of intensive clinical experience, that:

(1.) the use of marihuana leads acutely and for several hours to days thereafter, to a disorder of thinking characterized by a general lack of coherence and exacerbation of pathological thinking processes;

(2.) that the effects of marihuana are cumulative; and

(3.) that after a period of prolonged use (six months to one year) of marihuana in frequent dosages (on the order of once daily) some chronic changes occur which are similar to those seen in organic brain disease — islands of lucidity intermixed with areas of loss of function.

As an example of these effects Dr. Powelson recounted his experience with a Ph.D. candidate in mathematics. After using marihuana daily for more than a year the student approached Dr. Powelson in a quandry. He said that his grades had taken a severe decline and that he no longer seemed capable of solving complex equations. Dr. Powelson said that this is a common manifestation of prolonged marihuana usage. That is, the frequent user accumulates the active ingredients of marihuana and soon loses his ability to reason in the abstract. Dr. Powelson reported similar findings with law and medical students. In his opinion, such losses in reasoning ability are not permanent. The effects, however, in most cases require more than one year of abstinence in order to achieve full reversal.

Dr. Henry B. Bruyn

Dr. Henry B. Bruyn, M.D., is the Director of Student Health at the University of California, Berkeley, and an associate of Dr. Powelson. He agrees with Dr. Powelson that marihuana is a dangerous, unpredictable drug which should not be legalized under any circumstances.

Dr. Bruyn noted that the psychological effects of acute intoxification with cannabis preparations have been described by a variety of authors over many years, but interpretation is difficult since the origin of the marihuana is not always clear and, therefore, its potency is impossible to quantify. The effects reported included euphoria, excitement, disturbed associations, changes in the appreciation of time and space, raised auditory sensitivity with elaboration of simple phrases or tunes, fixed ideas, emotional upheavals, illusions, and hallucinations.

Dr. Bruyn said that most users of marihuana in middle class America have little knowledge of what to expect from a high quality cannabis preparation and also have little inclination or ability to "complain to authority or to their retail resource."

Health education in elementary and high school is, in Dr. Bruyn's opinion, a crucial factor in attacking the problems of drug abuse by young adults and students. If individual behavior is to be modified and changed, education seems to be the most promising approach. Health education ranging from kindergarten through twelfth grade, in Dr. Bruyn's view, should include frequent presentations on the effect of chemicals on the mind, the proper use of drugs, and the disturbances of the mind.

In Dr. Bruyn's view, from 20 to 35 per cent of college students in metropolitan areas have had some experience with marihuana. LSD is being abused by a much smaller number of students to the extent of 2 to 10 per cent. The major problems associated with these two drugs arise chiefly from their hallucinogenic effect. Chronic, regular use of either substance is incompatible with successful academic work. Untoward reactions to both are similar, but far less frequent and intense in the case of marihuana.

Dr. Hardin B. Jones

Among the most conservative opponents of relaxation of drug laws is Professor Hardin B. Jones. Dr. Jones is a Professor of Physiology and Medical Physics at the University of California, Berkeley. His course in drug abuse at the university is among the most popular on campus.

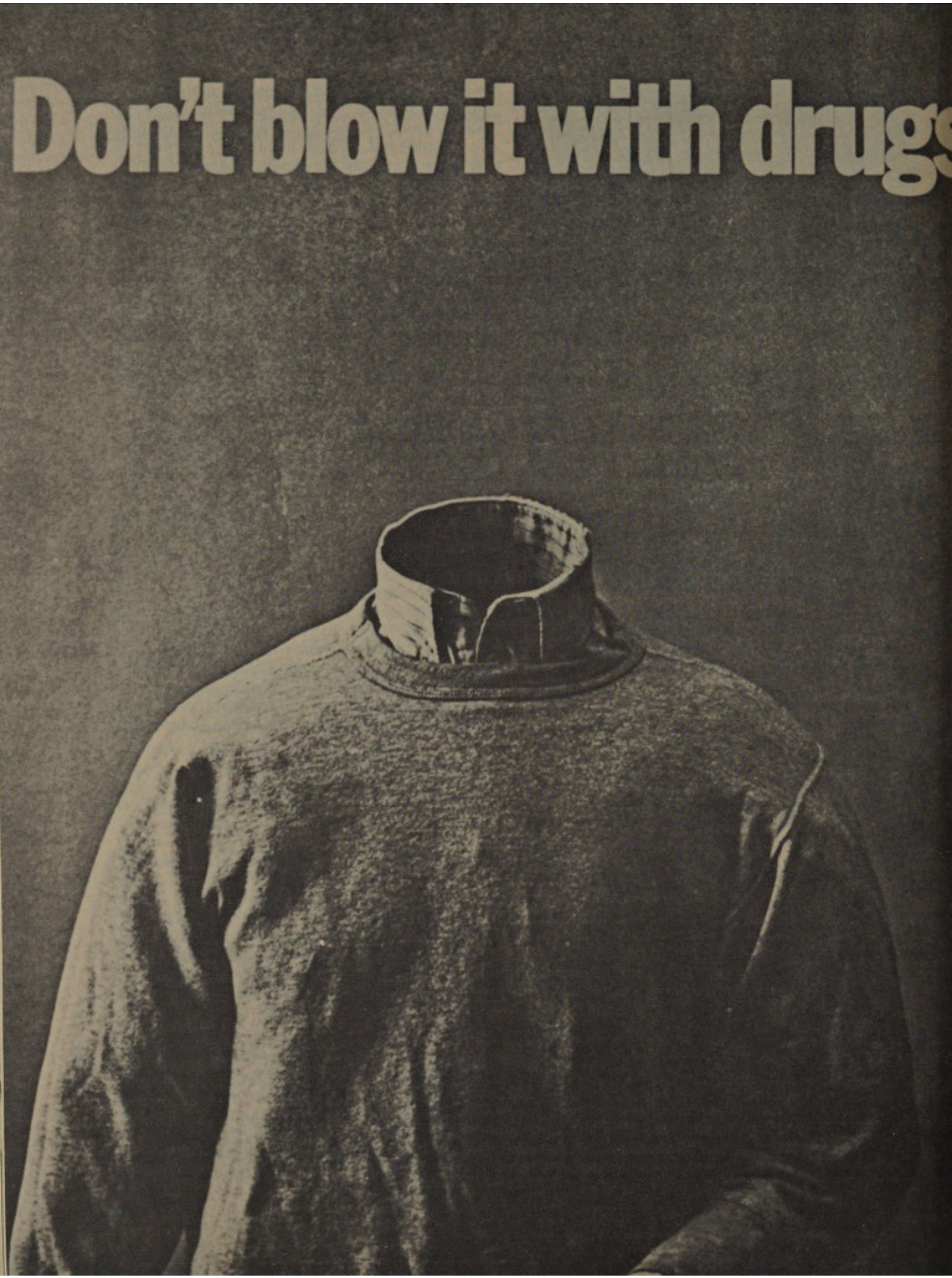
In Professor Jones's opinion drug consumption is rising across the country at a rate of seven per cent per month. As drug usage increases, according to Professor Jones, so does its abuse. He said that the threat of drug abuse

Decorative accessories for homes and apartments have enjoyed extreme popularity in recent years. Posters are particularly popular among today's youth. Although most are humorous or purely ornamental, many contain social commentaries of a highly compelling nature.

to the next generation makes it America's most crucial domestic problem. He went on to say that present resources to attack the problem are insufficient. Each must be organized to mobilize all levels of society and especially to involve parents and educators more deeply.

Dr. Jones suggested that action to reduce the "drug craze" must be focused upon lessening the appeal of drugs. The growth phase of drug use is due to the social climate in which it is argued by "those in the upper strata of society" that drugs offer "exciting new mental experiences." He cited as an example drug-oriented phonograph records popularized through radio disc jockeys. He also criticized the news media for the unwarranted widespread publicity given to Dr. Timothy Leary which unfortunately glamorized drugs in the eyes of impressionable youth. Expanded use of drugs is facilitated by the easy availability of illicit marihuana, "speed" and some other dangerous drugs.

Dr. Jones recommended that public leaders should avail themselves of every opportunity to warn parents, educators, and all who can exert influence on the young about the seriousness of the drug abuse problem. Leaders must seek better solutions for the drug problem than have been found to date. Establishing task forces of qualified persons may be the best mechanism for this search. Their mission should include the development of programs in education, advertising, law enforcement, and medical care and rehabilitation of drug users.


Don't blow it with drugs

Chapter 13
INTERVIEWS OF NEW YORK CITY AUTHORITIES

Purpose

The Commission interviewed several very knowledgeable authorities in New York City from April 6 through April 9, 1971 concerning drug treatment and rehabilitation programs in that city.

New York City has about 100,000 known heroin addicts, the most serious problem in the United States. The administration in that city has also had the longest experience in devising and implementing treatment and rehabilitation programs. The total cost of these programs is now over $100,000,000 a year, yet the results achieved have been minimal.

During our talks with authorities of these programs we learned about the various modalities, their characteristics, shortcomings and beneficial aspects. These findings enabled us to make appropriate recommendations of the best modalities for Illinois.

Dr. Harvey Gollance

Dr. Harvey Gollance is Associate Director of the Beth Israel Medical Center and the Administrator of that facility's Methadone Maintenance Treatment Program. Interviewed along with Dr. Gollance were Mr. Sten J. Friedman, Assistant Director, and Mr. Edward Lichtman, Administrative Assistant.

Methadone is a synthetic drug developed by the Germans during World War II when their morphine supplies were beginning to dwindle. Dr. Gollance explained that the objective of the methadone maintenance programs is to return the opiate addict to society as a productive member. Oral doses of methadone cause addicts to lose their "heroin hunger." Moreover, it blocks the euphoric effects of subsequently administered heroin. The major shortcomings of methadone is that pharmacologically it is a narcotic and has addictive qualities similar to the opiates. Although it produces lit-

tle or no euphoria its discontinuation does result in withdrawal symptoms.

The principle of the Beth Israel Program is to maintain an addict on methadone, much as a diabetic is maintained on insulin. In theory, the addict learns to forego his desire for euphoric escape from reality. Further, since he has no heroin needs to support, he ceases his involvement in crime and illicit drug traffic, and resumes a productive role in society.

The Beth Israel Program has been in operation for seven years, and currently is treating about 3,000 patients. It receives about 600 applications for treatment per month and currently has 3,000 applications pending. Admission is totally voluntary, the only criteria being a minimum age of 18 years and a minimum of two years addiction to heroin.

The program has three phases which are designed to gradually detoxify the heroin addict and thereafter control his habit through regular doses of methadone while he leads an otherwise normal life.

Beth Israel has a 20 per cent dropout rate. Of those 20 per cent, most leave the program for reasons other than their own volition.

Dr. Gollance cited a study of criminal records to compare patients in the Beth Israel Program with addicts who had merely undergone detoxification at government facilities: three years before entering methadone maintenance, his toxification at government facilities; three years "patients" averaged 120 arrests per 100 "patients" per year, and the detoxified "addicts" 131 arrests per 100 "addicts" per year. After four years on methadone maintenance, these same groups were studied and the results showed 4.5 arrests per 100 "patients" per year, as opposed to 134 arrests per 100 "addicts" per year.

He said that these dramatic figures illustrate that the opiate addict is not basically a criminal, but engages in criminal activity almost exclusively to maintain his habit. The cost of maintaining a heroin habit in New York is $30.00-$35.00 per day, so the addict must steal goods worth 3-5 times that amount. If jailed, he costs the taxpayer $4,000-$7,000 to keep in confinement. On methadone maintenance, however, 25% have productive jobs upon entering the program, 50% after six months, 80% after two years, and 92% after three or more years. Moreover, methadone maintenance removes the dangers of heroin overdoses on the street—a major problem in most big cities.

Beth Israel considers addiction a medical problem, and therefore insists that all its clinics be affiliated with a hospital and have professional personnel available at all times. Each clinic is equipped to handle a maximum of 125-150 patients.

According to the persons interviewed, diversion of methadone from the Beth Israel program is not a significant problem because of their strict control over distribution. Dr. Gollance complained that major diversion does occur in other programs where controls and records are not maintained. To his knowledge, 6,000 persons were undergoing methadone maintenance in New York City. This is a small number, however, when one considers that there is an estimated 100,000 in the city.

Mr. Friedman theorized that the reason for the purported decline in the use of psychedelic drugs could be that the hallucinogens are "experiential" drugs while barbiturates and opiates are "deadeners." He believes that the persons who tend to use the experiential drugs do not have emotional problems that heroin addicts usually display. Moreover, they are more amenable to public education campaigns against drug abuse.

Mr. Lichtman is a former heroin addict now on methadone maintenance. He started using heroin at age 15 and continued for 11 years, spending four years in prison, and three terms in the Federal Hospital at Lexington. He was arrested 28 times with 17 convictions.

Having been on methadone for five years, he said he would never give it up because he could not go back to his former life style. He said that for truly hard-core addicts, methadone is a more practical, optimistic treatment than the "therapeutic community" approach.

Dr. Henry Brill

Dr. Henry Brill is the Director of the New York State Department of Mental Hygiene, Pilgrim State Hospital, Long Island, New York and Advisor to the New York State Narcotic Control Commission. He is an eminent drug authority and the first expert to explode the myth of the so-called "British System."

He explained that the original British system was designed to cope with a problem unlike that confronting the United States today. There was at one time a small number of addicts in that country (300) who were obtaining their drugs through legitimate sources. The "Sys-

tem" proposed to remove the profit element from drug traffic by dispensing heroin to registered addicts in government-operated clinics. However, there ultimately were no registrations and no clinics, and physicians freely prescribed narcotics to addicts. In the wake of this practice, the number of addicts grew to around fifteen hundred.

In 1968, the system began to be implemented more in accordance with its original design. Registration of addicts was required, clinics were established, and physicians were no longer eligible to prescribe heroin or cocaine to addicts. The clinics would issue prescriptions for heroin in doses beginning at one to two grains per day with gradual tapering off. All patients are on an ambulatory basis. The addict status as such is determined by the clinical judgment of a physician.

Dr. Brill stated that the British government failed to recognize the contagious potential of drug abuse, especially among the young. It is estimated that there are now 2,000 to 5,000 new addicts in that country — most of whom are among the young.

Dr. Brill has been Chairman of the Evaluation Committee of the Dole Methadone Maintenance Program since 1966. He said that he is convinced that methadone maintenance can be a great help to hard-core addicts, but only if administered in a highly structured, tightly controlled program. He said that the new Federal Guidelines on methadone treatment, published on April 2, 1971 in the Federal Register provide for appropriate controls.

He explained that methadone, when administered orally, produces physical addiction similar to heroin, without the mental experience. However, if it is injected it produces all the mental effects of heroin. It is better to maintain on oral methadone rather than oral heroin because methadone is a slower drug, it builds up a threshhold more slowly and holds it more steadily. It is this steady threshhold which takes away the mental effect.

Diversion from methadone programs is a serious problem if there are inadequate controls over its distribution or if it is administered in a form which is suitable for injection.

Referring to chronic addicts who refuse any form of treatment, Dr. Brill suggested that there be established a procedure for the civil commitment of recalcitrant heroin addicts which would provide for compulsory rehabilitation. In such cases, the treatment facility should be given full authority over the treatment of the addict, and law enforcement agencies should not interfere unless the treatment director admits his inability to rehabilitate an addict. He estimated that the cost would be $6,000 - $9,000 per year in such a program.

Speaking with Edward Hammock, Executive Director of Daytop Village in New York City (right foreground), and Charles Devlin, Director of Rehabilitation Services (left foreground) are (left to right) Warren Smoot, Illinois Assistant Attorney General; Charles Siragusa, Commission Executive Director; Commission Co-Chairman Henry J. Hyde; Representative Joseph Sevcik and Commission Chief Counsel Roger C. Nauert.

Dr. Brill stated that the concept of "maturing-out" of opiate addiction is largely a statistical judgment for which there is no physiological evidence. Rather, social pressure and the increased difficulty in obtaining drugs by older persons may cause them to abandon their habit in their later years.

Edward Hammock

Mr. Edward Hammock is Executive Director of Daytop Village in New York City. With him during the interview were Mr. Charles Devlin, Director of Rehabilitation Services, and Mr. Walter Collier, Director of Research.

They explained that Daytop Village is a private drug rehabilitation program which utilizes a psycho-therapeutic community approach to treatment. Founded in 1963, the program currently has 422 "residents" and 70 staff members. There are four facility locations in New York City and one in New Jersey. Funding comes through the New York State Narcotics Addiction

Control Commission ($1,575,525 in 1970), the Model Cities Program in New Jersey ($123,000 in 1970) and the New York City Addiction Services Agency, which distributes O.E.O. funds ($196,000 in 1970).

Daytop Village is a purely voluntary treatment program, although courts will often condition probation of drug offenders on their admittance to Daytop. Residency usually averages nineteen to twenty months. The approach is similar to the therapeutic community of Synanon in California, but at Daytop Village there is strong emphasis on re-entering the addict into society.

Mr. Hammock estimated that in New York City there are 16,000 addicts currently in programs similar to Daytop, and 5,000 to 7,000 undergoing methadone maintenance. He said that in relation to the estimated 100,000 addicts in New York, this is a small number. But he added that Daytop has given rise to many similar facilities all over the country including Chicago's Gateway House.

Mr. Hammock criticized the practice of the New York State government in distributing funds freely to new, highly speculative programs while other programs, which have proven their merit, are unable to expand or improve their operations. He said that more emphasis should be placed on drug abuse prevention, since rehabilitation is merely an inadequate attempt to treat a problem after the fact.

All of the Daytop representatives agreed that methadone maintenance without concurrent psychotherapy is not a legitimate treatment modality since there is no effort to eventually withdraw the addict from methadone. Methadone maintenance is most successful with the hard-core addicts in their middle or upper years. The average age at Daytop, in comparison, is 22.7 years, which demonstrates the need for many treatment modalities to accommodate the many different types of addicts. This problem is intensified by the fact that heroin addiction continues to filter down to more youthful addicts every year.

Dr. Donald B. Louria

Dr. Donald B. Louria is an eminent author and authority on the subject of drug abuse. He is president of the New York State Council on Drug Addiction, Associate Professor and Chairman of the New Jersey College of Medicine.

Dr. Louria stated that the key to success in any modality of drug treatment is the motivation of the patient. There is no "best" modality, because addicts vary as to the treatment to which they will best respond. Generally, methadone maintenance works well for older, better-motivated persons, while therapeutic communities have more success with the young. However, all programs face high dropout rates with the very young, primarily because they are the least motivated. This is unfortunate because the "street addict" is usually much younger than the addict undergoing treatment. Thus, the most needy group of addicts has the smallest probability of rehabilitation.

He is pessimistic about ambulatory methadone maintenance because the ordinary program does not have the personnel to afford adequate controls. He described methadone administration through private physicians as "certain disaster" because overprescribing and diversion are inevitable.

Dr. Louria noted that much work remains to be done in developing treatment modalities on drug abuse problems outside of narcotic addiction. At the present time there are no known medical treatment methods for drug dependent persons other than narcotic addicts.

All drug treatment programs should have an accurate and reliable evaluation system in order to collect data which may be used to determine which characteristics will make an addict respond favorably to a particular form of treatment.

For the unmotivated, there is no alternative except civil commitment, psychiatric help, and a greater impetus to become motivated. In New York State there is such a program at the Bayview Rehabilitation Center which may be entered voluntarily, through the petition of an interested party, or through the judicial process. Commitment is for three years (five years for felons) but the doctors and administrators of the treatment facility may terminate residency at any time. Residency usually lasts nine months. The success rate of those who remain free from drug abuse is about 40 per cent.

Dr. Louria does not favor the legalization of marihuana. Among other reasons he noted that: (1) there is still much uncertainty as to the long-term effects of the drug; (2) it would add to the population of intoxicated persons in our society (3) there is a 1 per cent risk of acute abnormalities, including panic and depression; (4) there is a 1 per cent risk that the chronic smoker will lose control and become a "pot-

head"; and (5) there is a 20 per cent risk that the user will opt for more dangerous drugs. He recommended, however, that the laws be made more flexible so as to distinguish the small-time user or seller from the importer or large-scale seller.

Benjamin Goldman

Mr. Benjamin Goldman is the Director of the Bayview Rehabilitation Center in New York City which is a facility of the New York State Narcotic Addiction Control Commission. With him for the interview were Commissioners Charles King, Dr. Seymour Joseph, and Mr. Meyer Diskind. The Bayview Center is a multi-modality drug treatment facility which admits patients through their own volition, on the petition of an interested person, or by order of a court. Whenever a civil commitment petition is pending an adversary proceeding is held wherein the person involved is granted all the procedural safeguards applicable to a criminal proceeding. The Center currently treats approximately 400 persons in its residence facility. 50 per cent of these are 18 and younger.

After certification to the Center, the patient is screened in order to determine the most appropriate approach for him, i.e., the degree of security required, the modality of treatment, and similar considerations. Thereafter, he is processed and examined physically and psychologically. Counselors set up an individual program for each patient, and each is assigned his own room.

In addition to the residence facility, Bayview operates five "aftercare" centers throughout New York City, which provide limited residence facilities, day-care service for educational and vocational training, field services which obtain urinalyses, and methadone maintenance where required.

The major drawback of the program is its cost. Since the ratio between staff members and patients is one to one, personnel expenditures are extremely high.

Chapter 14
CHICAGO HEARINGS: AN OVERVIEW

Introduction

The Commission held its first series of public hearings in Chicago on October 20, 1970. They were conducted with complete partiality and as a forum for informed debate concerning all aspects of the drug problem. Witnesses invited to appear before us included those persons who are officially involved with one or more disciplines and those from the private sector who demonstrated an abiding interest in the drug problem.

Any responsible individual who believed he had a contribution to make to the hearings was publicly invited to communicate with the Commission for scheduling at a future date. We made it a point to encourage opposing views on relevant controversial issues.

We publicly stated that the primary purpose of the hearings was to report our findings to the Illinois Legislature so that it could determine whether changes were indicated in the laws of Illinois in order to protect the public peace and welfare.

The secondary purpose of the hearings was to inform the members of the Illinois Legislature and the public at large about the drug problem. In that regard the Commission lifted its traditional ban on the use of photographic and sound recording devices because the hearings were not of the usual adversary-type that characterized previous hearings regarding organized crime and racketeering activities. Each witness, however, was given the option to permit or refuse audiovisual recordation of his testimony.

The initial hearings were designed to obtain an overview of the problem and were addressed to the following, general topics:

The Drug Revolution

Characteristics of The New Drug Culture

Law Enforcement

Addiction

Methadone Treatment of Drug Addiction

Rehabilitation

Legislation

Drug Abuse on Campuses

Corrections

Research

Drug Abuse in Industry

Andrew C. Tartaglino

Mr. Andrew C. Tartaglino is the Assistant Director for Enforcement, United States Bureau of Narcotics and Dangerous Drugs, Washington, D.C. Because of unforeseen circumstances he was prevented from appearing before the Commission in person. Instead, he forwarded a prepared statement which was read by Mr. Gene Haislip, Special Assistant to the Deputy Director of the Bureau of Narcotics and Dangerous Drugs.

In his statement Mr. Tartaglino said that deaths from drug use in some areas of the United States "exceed (each) area's casualties in Vietnam." Of the fatal drug victims, Tartaglino said: "Many had just returned from Vietnam. Many were not old enough to qualify for Vietnam. A good number of them were not old enough to drive a vehicle. Some of them had just left the Cub Scouts." He also said that the demand for heroin in the United States has caused former members of the armed services and active duty servicemen "to try a hand in the heroin traffic. They are less organized than the veteran criminals . . . but they pose a serious problem."

The primary purpose of Mr. Tartaglino's testimony was to provide the Commission members with a sketch of the various forms of narcotics and dangerous drugs and to outline the routes of illicit drug traffic originating in both the Eastern and Western hemispheres.

Mr. Tartaglino, along with his superiors in the Bureau of Narcotics and the Justice Department had hosted the Commission during a two day briefing on the drug problem in Washington, D.C. earlier in the month.

It was Mr. Tartaglino's conclusion that Illinois, along with the rest of the nation, is in the midst of a drug abuse crisis. He noted that in the mid 1960's a "drug revolution" began. Drug abuse became socially acceptable in many quarters of the nation from the ghettos to suburbia. In addition to the growing acceptance there was also a tremendous increase in both the volume and variety of drugs. Hashish, which was relatively unknown on the American illicit drug market, became the drug of choice of those who wanted a more concentrated and potent form of marihuana.

In addition to the many stimulants and depressants, the psychedellic drugs appeared on the drug scene. Clandestine laboratories manufacturing synthetic drugs sprang up all over the country. In 1969 alone, the Bureau of Narcotics and Dangerous Drugs seized 48 illicit laboratories in more than a dozen states.

Mr. Tartaglino revealed statistics which clearly showed that, as a nation, we are suffering terrible losses. Between 1960 and 1964, there were approximately 300 deaths in the United States related to heroin. From 1965 to 1969 there were almost 3,000 deaths. In 1969, 224 of these deaths were teenagers and 20 of them were 15 years old and under.

In New York City there are approximately 3 deaths daily which are directly attributed to the use of narcotics. In Philadelphia between January and May of this year the Medical Examiner's Office reported an increase of approximately 86 per cent over the same period of 1969. Similarly alarming statistics were cited in the cases of Washington, D.C., Dade County, Florida, the Bakersfield Area of California and other metropolitan centers.

Mr. Tartaglino disagreed with those who would legalize marihuana. He observed that most of the marihuana found in the illicit traffic in the U.S. has been smuggled across the Mexican Border. Recently, however, increasing amounts of marihuana have been reaching the U.S. from the Far East, Africa, the Middle East, the Caribbean, and South and Central America. Last year the Bureau of Narcotics seized 55 tons of marihuana in the U.S.

Mr. Tartaglino urged the State of Illinois to adopt a model state form of the recently enacted Federal Uniform Controlled Dangerous Substances Act.

The Uniform Controlled Dangerous Substances Act, in essence, shifts the federal narcotics enforcement emphasis from user to pusher and producer. The new law de-emphasizes punishment of drug users in favor of educational programs aimed at preventing a person from taking up the use of narcotics and dan-

gerous drugs. It reduces the crime of possessing marihuana from a felony to a misdemeanor. More importantly it reduces the first offense possession of *any* drug from a felony to a misdemeanor.

On the other hand, stiffer penalties are provided for manufacturers and sellers of narcotics and dangerous drugs, including a possible life sentence for those involved in organized crime. Another provision would allow judges to impose an additional 25-year prison sentence on "special dangerous offenders" convicted of drug violations. The law also tightens restrictions on the legitimate sale and manufacture of drugs and arms federal narcotics agents with broader search powers pursuant to court authorization.

This latter power has been inappropriately called the "No-knock" provision. Under the act federal officers may enter private premises without announcing their office in strictly defined instances (where there is a danger of evidence being destroyed or a high risk to the lives of the agents) and only upon receiving a warrant from a federal court pursuant to sworn testimony.

Included in the law is a provision for a study of the effects of marihuana. According to Special Assistant Haislip federal officials hope that the reports of this study will be given the same respective response as the 1964 Surgeon General's Report statistically linking cigarette smoking with lung cancer.

Mitchell Ware

Mr. Mitchell Ware, Superintendent of the Illinois Bureau of Investigation, was extremely critical of several Cook County Circuit Court judges for what he called "their failure to enforce state drug laws involving marihuana". He said that too many people in Illinois have come to believe that marihuana is not harmful because of the judges' opinions that its use does not lead to harder drugs and cannot be addictive. Mr. Ware declined to name those judges who were the subject of his criticism.

Mr. Ware also criticized Cook County prosecutors for being "too lenient" against drug sellers. In explanation he suggested that the Cook County State's Attorney's Office could be more circumspect in permitting reduced pleas in the case of drug pushers.

Mr. Ware also told the Commission that in the last several weeks his agents had uncovered a number of "bogus" treatment centers "where drug addicts are treated by phony doctors with nothing more than vitamin pills". He did not name the "centers" or disclose their locations. But he said that they have made substantial profits off "gullible patients".

In response to questioning Superintendent Ware urged the state to adopt a licensing act which would establish higher standards for drug rehabilitation centers.

George Simms

Mr. George Simms, Assistant Deputy Superintendent of the Chicago Police Department, recounted his experiences as a District Commander in the various black ghetto areas of Chicago. He blamed the recent proliferation in drug abuse upon a new "permissiveness" extant in our society. He called for increased penalties against drug sellers and manufacturers and decreased penalties for drug users, particularly first offenders.

Joseph A. Bou-Sliman

Mr. Joseph A. Bou-Sliman, Director, Central States Institute of Addiction in Chicago, pointed out that drug addicts and alcoholics in most cases have the same mental set and psychological deficiencies. He called for the enactment of a new commitment law which would differentiate between civil and criminal commitment procedures. He cited the laws of California and New York as models for emulation in Illinois. The Commission staff is currently studying these commitment laws and has viewed the California commitment program in action during its recent tour of California law enforcement, treatment, and correctional facilities.

Mr. Bou-Sliman also called for state funds to establish a vigorous addiction treatment program in Illinois. The facilities envisioned by Mr. Bou-Sliman would be similar to those currently financed by the Federal Government. A leading example is the Federal Treatment Center at Lexington, Kentucky.

Dr. Jordan Scher

Dr. Jordan Scher is the Director of the Chicago Psychiatric Foundation and Ontoanalytic Institute in Chicago, Illinois. Dr. Scher had just completed an exhaustive study on narcotics and drug problems in private industry. It was

his finding that a tremendous increase in employee absenteeism, thefts and related problems has occurred during the past five years. He stated that at the present time little efforts have been undertaken to detect the drug user during the recruitment and selection periods. Dr. Scher said that he favors union contracts which would provide for industry sponsored and financed treatment of addict employees. He has projected a 30 per cent increase in the instances of drug abuse in industry during the next year.

According to Dr. Scher the greatest problem presented by drug abuse in private industry is the dependency created by addicting and habit forming drugs. In his opinion the use of drugs creates an inability to confront reality and to reach decisions. As a consequence, an employee who is seriously involved with drugs, to the point of dependency, will very often "opt out" of a decision-making situation, thereby producing delays and other ineconomies in the business world.

Dr. Scher did not agree with those witnesses who urged the classification of marihuana with "hard drugs". It was his opinion that marihuana is comparable to alcohol in its affect on mental processes and motor activities. He noted that locally grown marihuana is extremely insipid when compared with other forms grown in equitorial regions such as Mexico and Vietnam. He suggested that because most youths in Illinois had been exposed only to local marihuana, and assumedly had not experienced the extreme effects wrought by imported marihuana, they are slow to accept the stern warnings of law enforcement officers, parents and school officials.

Dr. Andrew J. Toman

Dr. Andrew J. Toman, Cook County Coroner, warned that an increasing number of addicts are dying from a combination of morphine and barbiturates or alcohol. "The type of morphine being sold on today's market has been cut

so often that the user is unable to acquire the same effect from the same amount as he could with previous purchases," Toman said, "so he resorts to the additional use of barbiturates or alcohol." Referring to this phenomenon, Dr. Toman explained that alcohol and barbiturates have a cynergistic effect on narcotics and most psychedellic drugs. The consequence is a geometrically increasing effect of the original drug as additional alcohol or barbiturates are induced into the system.

Dr. Toman noted that the same cynergistic effect is operative when the marihuana user accompanies his smoking habits with the taking of alcohol. In response to questioning, the coroner agreed that this phenomenon, if permitted to become widespread, would be an extraordinary menace to the highways of Illinois. Dr. Toman's testimony was supplemented by a chart which reflected the number of narcotic overdose deaths detected by his office in recent years.

Chapter 15
CHICAGO HEARINGS: LAW ENFORCEMENT

Introduction

The Commission's second series of public hearings were held in Chicago on October 21, 1970 and represented a continuation of the overview of the drug problem, with emphasis on police and prosecution viewpoints.

Edward V. Hanrahan

Mr. Edward V. Hanrahan, State's Attorney of Cook County, proposed a new legislative program to fight drug abuse. Hanrahan testified that, "we are faced with not only a very serious problem but a plague. Our office will present a program to the General Assembly that would considerably strengthen our present laws. We will also be making recommendations to improve the facilities for addicts and court procedures."

He said that he would support any recommendation made by the Commission which would reduce the penalties for possession and sale of marihuana and would increase those for the sale of amphetamines and barbiturates.

Hanrahan stated that "marihuana is not properly categorized as a narcotic drug." Scientifically, marihuana is not a narcotic, though Illinois law designates it as such. There must be a differentiation between marihuana and heroin in the law.

The penalty for selling narcotics is 10 years in prison. "Any judge is reluctant to impose that penalty, and any prosecutor is reluctant to pursue it." As a result, he said, there is much reduction of charges from sale to possession. "The seller, the real poisoner of our society, can escape with the same kind of penalty as the one in possession," Hanrahan said. "That penalty is up to a $1,000 fine and up to a year in jail: and I can't think of a case where the maximum penalty has been imposed."

Again emphasizing the need of severe penalties against pushers of narcotics Hanrahan

testified, "I remember a sentence of 40 years given a narcotics seller. That judgment had startling punitive effects. That is the kind of inhibitive, realistic penalty people in this society want and it is incumbent on our judicial system to provide it."

Mr. Hanrahan also recommended that the Commission use its good offices to "urge the federal government to regulate the exhaustive production of amphetamines and barbiturates by our pharmaceutical companies." It has been estimated that such companies now produce enough pills for every adult American to have 40 doses daily.

Mr. Hanrahan said that he feared the growing local drug problem would make it necessary to open a third narcotics court in the Circuit Court system of Cook County. He said the court facilities are inadequate to handle the average daily load of 400 narcotics cases. Approximately 70 per cent of the cases involve marihuana and 30 per cent hard drugs. Fifty per cent of the marihuana users are under 25 years of age, he said. He explained, "We had only one narcotics court when I took office in December, 1968, and a tremendous surge in drug use has greatly increased our prosecutions." State's Attorney Hanrahan denied a complaint made the day before by Mitchell Ware that his prosecutors were not using the necessary vigor against drug sellers. He said that "our prosecutive decisions are made specifically on sound realistic reasons and based in the law. We are not kissing drug cases out of court."

He announced further that members of Chicago's Blackstone Rangers street gang had murdered "chief" black narcotic peddlers who failed to make shake down payments demanded by the gang. He declined to give further details such as the number of peddlers slain. Mr. Hanrahan was critical of judges who were lenient toward defendants charged with sale or possession of narcotics.

William Bauer

Mr. William Bauer, the United States Attorney for the Northern District of Illinois, joined Mr. Hanrahan in opposition in any move to legalize possession of marihuana. "We won't solve anything by legalizing it," he said. "Youth cannot withstand temptation now."

He declared that heroin pushers are more dangerous to society than murderers or armed robbers.

Both Bauer and Hanrahan agreed that Illinois drug laws were outdated and unrealistic. Bauer urged the Commission to recommend new state laws to deal with the growing drug problem and to provide for cooperation among all state and federal law enforcement agencies operating in the state. Mr. Bauer's recommendation would include statutory provisions requiring the exchange of narctoic reports among the various law enforcement agencies operating in the state.

Lt. William Mahoney

Lt. William Mahoney, head of the narcotic unit of the Chicago Police Department, testified concerning the problem of narcotics and dangerous drugs in Chicago. He was accompanied during his testimony by Det. Bernard Brown, a noted authority on the law enforcement aspects of the drug problem. Both Lt. Mahoney and Det. Brown expressed extreme concern over the growing number of drug overdose deaths in Chicago. They were also unanimous in opposing any move to legalize marihuana. Both underscored the need for cooperation with federal law enforcement agencies if the proliferation in drug abuse is to be brought under control.

John G. Evans

Mr. John G. Evans is the Regional Director of the U.S. Bureau of Narcotics and Dangerous Drugs in Chicago. He gave further testimony on the sources and traffic of drugs as they effect the State of Illinois. Referring to the recent proliferation of drug abuse and narcotic overdose deaths, Mr. Evans suggested that this

nation is on a course of self-destruction unparallelled in our history.

Mr. Evans offered positive testimony concerning the possible influence of organized crime in Illinois rock festivals. He also mentioned that recent reports indicated that profits from the sale of drugs had recently become an important new source of revenue to the Black Panther Party across the United States.

William Cahn

Mr. William Cahn is the District Attorney, Nassau County, New York and President-elect from the National District Attorneys Association. He is also an attorney for the Association's Committee on Narcotics Addiction. He testified that *users,* not sellers, are the strongest source in spreading drug addiction and that the drug users should be confined in rehabilitation institutions. He said that, "Users seek to corrupt their friends in order to have company in their misery." He added, "Many narcotic addicts become at least part-time pushers in order to get money to support their own habit."

He noted that in New York users can be confined in institutions by civil commitment, or at the request of a person charged with using drugs. As stated above this commitment program is currently under study by the Commission's staff.

Mr. Cahn praised the activities of a Nassau County-operated narcotic rehabilitation center. The center is known as "Topic House" and is administered by former addicts. He underscored the fact that the state supported treatment facilities do not bear the indicia of criminality even though most of the residents are present through court referral.

Osie Dompier

Mr. Dompier is the Special Agent in Charge of the U.S. Bureau of Customs in Chicago. He related that his office has worked in close harmony with the Bureau of Narcotics and Dangerous Drugs as well as state and local authorities with narcotic and drug jurisdictions. Mr. Dompier's job is made more complex because of the large number of nationals which enter greater Chicago from both water and air ports of entry. Very frequently these visitors carry large amounts of contraband drugs on their persons. He indicated that plans were in preparation to strengthen the Lake Michigan ports of entry because of inadequate investigative staffing.

Daniel D'Aquila

Chief Daniel D'Aquila of the Downer's Grove Police Department appeared with Sgt. Louis Fulgaro, his principal narcotic officer. He told the Commission that although surrounding suburbs have frequently refused to admit their drug problems until recently, his department began working on the problem six years ago. "The welfare of our young people is more important than adverse publicity," he said.

Chief D'Aquila said that narcotics arrest publicity gave Downer's Grove a bad name initially, but that his community is now one of the leaders in the dissemination of drug abuse information in Illinois. He noted, however, that whereas there was approximately one narcotics arrest per month in 1965, there are now about eight per month. Downer's Grove has a population of 31,500. At the time of his testimony 72 persons had been thus far arrested during 1970 in Downer's Grove. He suggested that the situation would be more severe had the department not started confronting the drug problem when it did.

Chapter 16
CHICAGO HEARINGS: THE DRUG REVOLUTION, PART I

Introduction

Our third series of public hearings was conducted in Chicago on December 17, 1970. A total of 12 witnesses testified concerning the drug abuse crisis in Illinois which has been characteristic of the "Drug Revolution" which began in the United States in the mid-1960's.

The topics covered were generally as follows:

Drug abuse among the youth

The prevalence of drug abuse and illicit distribution at rock festivals

The marihuana culture

The impact of mass media advertising

The role of the mass media in drug abuse education

Private treatment and rehabilitation

Dr. Joseph H. Skom

Dr. Joseph H. Skom is the Chairman of the Illinois State Medical Society Committee on Narcotics, Chicago. His testimony concerned the underlying reasons for the drug abuse problem in Illinois, the first being the ready availability of drugs on the illegal market. Equally important in his view are the motivations of the persons who turn to drugs. Drug abuse, he explained, actually begins as merely a symptom of some deeper underlying problem. Many persons start out on drugs because of feelings of depression, disillusion, disenchantment or boredom. When this initial drug proves ineffective for self-therapy, the user will progress to different drugs until he comes upon one which either produces the desired therapeutic effect, or, more likely, overwhelms him with its effects.

Another major incentive to experiment with drugs is peer group pressure. He urged that parents should try to neutralize or counteract

this pressure by citing the many ill consequences that are attendant to drug abuse.

On the subject of marihuana, Dr. Skom explained the active ingredient, tetrahydrocannabinol, will produce the same mind-shattering effects as LSD if ingested in very large quantities.

In response to a question by Co-Chairman Gerald W. Shea concerning the dependence-liability producing qualities of marihuana, Dr. Skom explained that although the drug produces no physical dependence, there is the likelihood of an emotional dependence:

> I think the evidence for the emotional or psychological dependence on marihuana is just as good as the evidence on the emotional or psychological dependence for some people on cigarettes and cigars. Yes, people do become emotionally dependent on marihuana. It has even been found that in some cases, no cannabis has been found in cigarettes purporting to contain marihuana, but the use, or the ritual involved in the use, may be something that an individual becomes dependent upon.

The actual psychological and physiological effects of marihuana depend to a great degree on the user and the surrounding circumstances. Much depends on what he expects, with whom he uses it, and his physical and emotional state at the time of use. These factors may change from day to day in the same individual.

Executive Director Charles Siragusa inquired of Dr. Skom whether he agreed with the proposition that marihuana use is conducive to an apathetic attitude and the desire to "drop out." Dr. Skom replied that marihuana produces "instant dropping out" and explained:

> Whether or not marihuana produces this denouement, or whether there is a group of individuals who are presently disposed to go this route and pick up the use of marihuana on their way into the dropping out process is very hard to determine. But the fact of the matter is that the habitual use of almost any drug will produce this result because often its effects are so overpowering that it produces in the user a similar dull, apathetic, broken-record type of personality.

Mr. Siragusa then asked Dr. Skom if he could discern a trend in Illinois for marihuana use to be followed by a rapidly increasing use of heroin, as was the experience in California. Dr. Skom replied:

> I think the truth is that the individual who takes a drug in order to feel better would use whatever drug is available. Since marihuana obviously is not effective self-therapy for many people, whatever drug is next available is the drug that is going to be used, and the individual continues selecting drug after drug until he gets one that either overwhelms him with its effects or, on the other hand, produces a therapeutic effectiveness. So it is easy to see that some people who are conditioned to a chemical substance will be starting on one drug and ultimately winding up on another.
>
> Now, the reason they will end up on heroin, as the last drug, is that heroin produces a physical dependence while some of the other drugs do not.

Co-Chairman Shea then asked Dr. Skom to elaborate on his theory that in most instances, persons who use drugs have other, underlying problems which are the cause of their resort to drugs. Dr. Skom explained that these persons often are troubled by feelings of disillusion, lack of hope, despair, desperation, depression or boredom. However, there are instances when ordinarily stable persons may experiment with drugs because they have heard that drugs offer excitement or "kicks." These persons generally all tend to believe that they are strong enough to handle their involvement with drugs, and soon are sincerely surprised when they realize that they have lost control and have become dependent.

With regard to the laws relating to drug abuse, he felt that because of their current harshness they were often subverted by well intentioned judges, prosecutors and arresting officers who would rather issue a warning rather than have to impose the severe mandatory penalties now required. For this reason he regards the current drug laws as unenforceable and ineffective. He suggested that they be changed to take into account the kind of person the offender is and what his motives are for engaging drug traffic. Penalties might be based on the amount of drugs involved in each case, and the law should draw a distinction between a true "sale" and an accommodation sale.

Captain Clyde W. Oliver

Captain Clyde W. Oliver, Chief, Criminal Investigation Section, Springfield, Illinois, was unable to appear. Sgt. D. L. McKinney and Cpl. Perryman appeared in his behalf. They brought with them motion pictures and still photographs of the Heyworth Rock Festival, held in Heyworth, Illinois. Between 50,000 and 60,000 persons attended the festival and it was estimated

that about 75 per cent of them were periodically "high" from using some form of drugs. They stated that there were tents and other facilities for the sale and manufacture of narcotics, as well as medical facilities to aid those experiencing "bad trips". They reported that in a few instances mothers had given drugs to their children.

There were 35-50 arrests made off the grounds, and there were at least 50 persons admitted to local hospitals suffering from overdoses and related side effects of drugs.

Carl Charnett

Mr. Carl Charnett is the Director of Dynamics, the Gateway House Foundation in Chicago. Gateway House is a non-profit organization which operates three residential in-patient facilities for the rehabilitation of drug addicts, and which are staffed primarily by ex-drug users. Their approach is the "therapeutic community", in which all residents must contribute to the operation of the facility, and each is given jobs and responsibilities commensurate with his demonstrated level of maturity. As they adjust to responsibilities, they are given more prestigious tasks. Relapses into immature behavior are severely sanctioned by the house community.

Mr. Charnett explained that his experience has shown that most drug users have an apathetic, depressed outlook on life from which they seek relief through drugs. The goal of Gateway House is to develop maturity, responsibility and self-respect and thereby eliminate the psychological desire for drugs. Overcoming the physical desire for drugs is not as difficult as the public often believes. He asserted that withdrawal symptoms for most heroin addicts are no worse than an ordinary case of the flu and last but a few days because of the high adulteration.

Senator Cecil Partee commented that this was not the case years ago when he was associated with the Cook County State's Attorney's office. "At that time the heroin being sold on the street was of a much purer nature. The reduced virulence of illegal heroin since that time has produced less severe withdrawal problems," Senator Partee observed.

The basic concept behind Gateway House is the belief that drug abusers are generally "infantile and untrustworthy." Extreme group pressures are exerted to force residents into rejecting their drug dependency and accepting mature responsibility.

Representative James Y. Carter mentioned that in his experience he has noticed a tremendous flood of pills and capsules distributed by the pharmaceutical manufacturers for purposes of advertising their products, many of which inevitably fall into the hands of drug abusers. Mr. Charnett agreed that this practice contributed significantly to the drug problem, and added that advertising which emphasizes quick relief from "sleeplessness" and "anxiety" through drugs tends to promote a drug dependent society:

> It is my belief that we are living in a drug oriented society, a society that is thinking instant comfort, and it is getting worse and worse. We cannot single out the younger generation and put the blame on them for drug abuse without first taking a good hard look at ourselves, our integrity, and what we tolerate and what we do not tolerate. We are setting very poor examples for the youngsters, and I would like a very strong look at the advertising policies existing in this country.

Mr. Charnett agreed whole-heartedly with the opinion of Co-Chairman Henry J. Hyde that the medical profession must establish discipline among its members to refrain from issuing "promiscuous prescriptions" which alleviate symptoms but do nothing toward curing the underlying ailments of patients.

Charnett was adamant in his opposition to legalizing marihuana. He noted that the United States is already "far too pleasure oriented" to permit the legalization of yet another mind-altering drug.

Gateway House is presently funded by the Illinois Law Enforcement Commission, the Department of Mental Health, and private contributions. It currently has 125 resident patients and a maximum capacity for about 200. Residency usually lasts for 18-24 months. Although there have been only nine graduates thus far, it is anticipated that 80-85 per cent will never again return to drugs. This estimate is based on results obtained by similar institutions in other states which have been operational for longer periods such as Daytop Village in New York.

Mr. Charnett was accompanied by four former addicts who are now residents at his Gateway House. The one common denominator that applied to all of them was that pressure from their peers in schools and neighborhoods was a contributing factor either to their introduction to drugs and/or gravitation to other drugs.

Charles Reese (ex-addict)

He is a black man who is 37 years of age, separated from his wife and four children, and a former ghetto resident of Chicago. He admitted using heroin for about 23 years until about 15 months ago. Marihuana was the first drug he tried but, because many of his neighborhood friends were using heroin, he soon gravitated to heroin. He related a tale of degradation caused by his heroin addiction that eventually led him to being found unconscious in a garbage pail, upside down.

Cynthia Rose (ex-addict)

She is a white girl, aged 22, who formerly lived with her middle-class parents in Oak Park. She said she had been using drugs since she was 14 years of age when she and her friends stole diet pill tranquilizers from their parents' home medicine cabinets. From that she went to marihuana, psychedelics and lastly to heroin. She financed her habit by passing bad checks and prostitution.

Tawney Guyon (ex-addict)

She is a white girl, aged 19, and the daughter of a wealthy downstate Illinois family. She said that an unhappy childhood caused by parental friction led her to use amphetamines at the age of 16 when she was in a boarding school. From there she used hallucinogens; "My whole life centered around drugs". She too financed her drug habit by passing forged checks and becoming a prostitute.

Phil Doherty (ex-addict)

He is a white youth, aged 19, who came from a lower income North Side Chicago family. His parents were divorced when he was three years of age. He spent most of his life living with either his working mother or his alcoholic father; the latter introduced him to liquor. In his early teens he began smoking marihuana, later he used psychedelic drugs and "speed", admitting "my body became a human garbage pail". He sold marihuana and psychedelics to his friends in order to sustain his own addiction.

James G. Hanlon

Mr. James G. Hanlon is Vice President and Manager of Public Relations and Advertising for WGN Continental Broadcasting Company, Chicago. His testimony concerned the efforts of WGN-Television and-Radio in their program against drug abuse. It consisted of three intensive campaigns throughout 1970, and was composed of announcements, special programs, interviews, and published material directed toward focusing public attention on the drug problem. The response to this program was much greater than anticipated, indicating a substantial need for more readily available materials and professional services to accommodate those who are attempting to fight drug abuse on a personal level.

Mr. Hanlon stated that the basic theory of the program was to remove the stylishness and vogue of being a drug user, and then supply drug users and parents with the facts about the consequences of drug use. He also asserted that it was the policy of WGN to refrain from broadcasting drug-oriented rock music, because the management recognizes the possibility that this type of music may tend to encourage impressionable young people to experiment with drugs.

Rep. Leland H. Rayson

Mr. Rayson is a member of the Illinois House of Representatives who has introduced bills during this session of the General Assembly which would change the current drug laws. He suggested that the penalties under the present laws are irrational and unrealistic. His proposal would remove all criminal sanctions for the private use of marihuana by persons 18 years of age and over, so long as the amount involved does not exceed 10 grams. Possession in excess of 10 grams would be a misdemeanor punishable by a fine of $1,000 and/or one year imprisonment. Sale, or possession with intent to sell, would be a felony, punishable by imprisonment for two to four years on the first offense and 10 years to life upon a second conviction.

He suggested that even though marihuana may be shown to have harmful effects, perhaps the professional elements of society, such as doctors, teachers, social workers, and others would be better suited to minimize these harms than the criminal justice system.

Dr. Henry A. Smith and Mrs. Joanna Smith

Dr. and Mrs. Smith are two of the founders of the Phoenix Academy in Wheaton, Illinois, a private organization of professional people directed toward the rehabilitation of drug users,

most of whom are required to pay for this treatment. Their approach is to present a comparative study of science, art, religion and "design" without drawing drug conclusions so that the "student" himself may make his own decisions. It is believed that in response to these ideas the students will reach out and develop their own characters, remove themselves from drugs and the drug scene, and become leaders and citizens working for the good of all humanity. This group now numbers more than 100 persons who come to weekly meetings from all over the state.

In 1969 the organization bought an experimental farm in Wisconsin. The purpose of this farm is to build character, body strength and responsibility in young people who tend and manage the farm. They report that persons who have participated in the farm program are confident that they will never again return to drugs.

They explained that it takes approximately three months of being free of the drug to begin to change the pattern of personality. Thereafter, it takes six months to get a basic idea of the student's philosophical motivations, and an additional six months to return the person to a productive place in society.

William C. O'Donnell

Mr. William C. O'Donnell is vice-president of the Columbia Broadcasting System and General Manager of WBBM Radio, Chicago. His testimony concerned the nature of the drug problem and, specifically, the role which broadcasters can take against it. He said: "Drugs are a problem in this nation. We, as broadcasters can perform a unique public service in combating this problem. We have the selling knowledge, the feel for our listeners, the personnel to make a positive contribution to this cause".

He suggested that the rising incidence of drug abuse may stem from the poor example of adults who rely on tranquilizers and pills to help them cope with life's troubles, and the impact of advertising these quick-cure remedies on all the media. He also suggested that there might be a connection between drug-oriented rock music and the tendency for some young people to experiment with drugs.


PATRIOTIC

Chapter 17
CHICAGO HEARINGS: THE DRUG REVOLUTION, PART II

Introduction

The Commission's fourth series of public hearings was conducted in Chicago on December 18, 1970. Six witnesses testified in continuing presentations concerning the "Drug Revolution." The topics receiving major attention were generally as follows:

(1) The impact of drug-oriented rock music

(2) Investigation of "head shops," retail stores catering to the drug culture

(3) The suburban drug abuse problem

(4) The Illinois Drug Abuse Program

(5) Drug abuse education programs in high schools

(6) The scope of drug prosecutions in Cook County

Roger C. Nauert

Mr. Roger C. Nauert is Chief Counsel for the Illinois Crime Investigating Commission. His testimony concerned a six week investigation into "head shops" in the Chicago area. "Head Shops," he explained, are establishments which deal in drug paraphernalia. He displayed hookah water pipes, Zig-Zag cigarette rolling paper, "roach holders" which are used to hold marihuana cigarettes while they are smoked, and psychedelic posters. He explained how these various items were being used either directly in the use of drugs or as evangelistic devices to extol the use of marihuana, hashish and other drugs. He stated that all these supplies were readily available, especially in the Old Town area and along Sheridan Road between Devon and Touhy, in Chicago. He too suggested a link between much of today's popular music and the drug scene. In his view the music frequently enhances the social acceptability of drug abuse and many times "duplicates" the drug experience.

He agreed with the statement of Co-Chairman Hyde that drug oriented rock lyrics provide a pattern of acceptability to drug use and establish a mood and a fertile area wherein young people can feel comfortable in the use of drugs.

Gene Taylor

Mr. Gene Taylor is the General Manager of WLS-Radio in Chicago. He said that he totally rejected the premise that song lyrics contribute to drug usage. Rather, he felt that lyrics are but a reflection of drug usage. He said that at the present time many of the song writers and performers are working on anti-drug music. He suggested that the performers and their life styles have a greater influence on young people because they tend to imitate them.

Erwin Weingartner

Mr. Erwin Weingartner is the Director of Student Services at New Trier East High School, Winnetka, Illinois. He testified that the drug education program at New Trier has encountered problems with a shortage of teaching materials and qualified teachers, as well as difficulties in organizing a community effort and evaluating the success of the program. He stated that it is necessary to design elements of the program which are suitable for various age levels of students and also for parents. He also suggested that a comprehensive drug education program should begin in the fourth grade and be continued through high school.

Arthur H. Pantle

Mr. Arthur H. Pantle was unable to appear, and Captain Robert Bonneville of the Glencoe, Illinois Police Force testified in his behalf. He spoke of the drug problem in Glencoe, and noted that it indicates a change in attitudes concerning drugs, for the problem at one time was confined to the lower class areas. He said that the problems of drug law enforcement in smaller communities are primarily that (1) undercover work is impossible because all members of the force are known in the community; (2) there is a shortage of manpower and resources; (3) parents refuse to recognize the problem or cooperate with police; and (4) the youths' code of ethics precludes them from disclosing information. He advocated close cooperation between suburban communities, especially the exchange of policemen for undercover work. He also noted the need for the development of educational materials which would be more effective and understandable for younger children in the fourth and fifth grades.

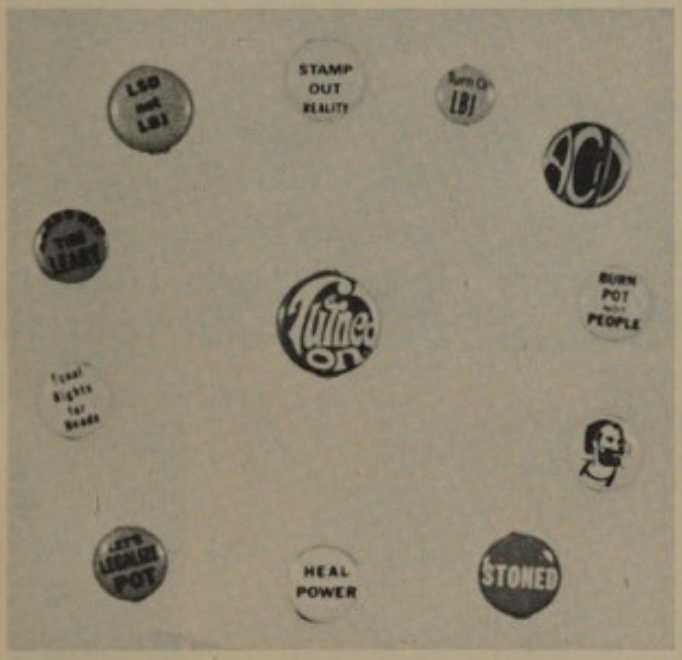
Posters evangelizing drugs have become very popular. Here "Uncle Sam" is surrounded by marihuana leaves. The caption "Feed Your Head" represents an invitation to alter one's perceptions by using drugs.

Dr. Jerome H. Jaffe

Dr. Jerome Jaffe is the Director of the Illinois Drug Abuse Programs in Chicago. He stated that the program currently treats almost 1200 people, with 700-800 waiting for treatment. The program is now decentralized, there being numerous centers where patients go for treatment. This appears to be more workable than

a single, centralized location because it makes the facilities more accessible to patients.

He noted that physical detoxification does not pose any particular problem, the withdrawal process taking about three weeks. However, the psychological rehabilitation of the patients is much more difficult and is the key issue. For this reason, it is often necessary to convince patients to stay on methadone when they would like to be off drugs altogether, so that they may stabilize their lives before withdrawing completely.



Various "campaign buttons" advocate the use and/or legalization of dangerous drugs. Sayings include "LSD not LBJ," "Stamp out reality," "Acid," "Burn pot not people," "Stoned," "Heal Power," "Let's legalize POT," "Equal Rights for Heads," "Hands off Tim Leary," and "TURNED ON."

He complained that there is now a projected need for a treatment capacity of 6,000-7,000 patients. The funds received from the Department of Mental Health are inadequate for the additional staff training and development of facilities. In addition, the pay scales formulated by the Department of Personnel are not competitive enough to attract badly needed professional people. He suggested that the operation of the Drug Abuse Program should be exempt from the Personnel Code.

He estimated that the cost per resident patient per year was $3500. At that rate, the state will have to outlay six to seven million dollars to make a significant impact on the known number of compulsive heroin users throughout the state.

Representative Tobias Barry observed that from a long-range point of view, it would make economic sense for the state to allocate more money for drug treatment and rehabilitation. Whereas, it costs the state $3,500 per year to treat a heroin addict, that same addict would otherwise be stealing up to $35,000 per year to support his addiction.

Dr. Jaffe added that the Illinois Drug Abuse Program has initiated contracts with certain not-for-profit corporations which permit patients to pay part of their own fees, thereby defraying part of the cost to the state. Representative Carter inquired whether this system would be confined to the methadone treatment approach, where the patient would be concurrently gainfully employed, and Dr. Jaffe replied that the situation is most conducive to the partial-payment system, although there are some methadone patients who require in-patient treatment and are unable to hold jobs.

Representative George Lindberg inquired whether Dr. Jaffe agreed with the theory of several California authorities that marihuana offenses should be categorized as a "quasi-crime", whereby offenders would not be given a permanent criminal record, but would be diagnosed for emotional or psychiatric problems and given the professional help or education they are found to need. Dr. Jaffe remarked that although some marihuana users are in need of professional guidance, the majority are not, and to establish this sort of program would divert resources from other treatment programs which are much more vital.

Representative Lindberg then asked Dr. Jaffe's recommendations as to the proper legal disposition of persons found selling or possessing small amounts of marihuana. Dr. Jaffe replied:

> If that is his only offense, I would say that the less we get involved in the court system, with the expenses of defense and prosecution, and the less we stigmatize young people, the more sense it is going to make in the long run. I think we have to recognize that for the last 10 to 20 years the penalties for possession of marihuana have been as severe as those for possession of heroin;

and under that kind of legal system we have watched the use of marihuana move up several thousandfold among young people. At some point, we certainly have to say, "I guess that doesn't work."

As soon as you group all drugs together you have made the first mistake. I think that different drugs present different risks; and if you want to change youth's attitudes toward all drugs, you fly in the face of their own experience. Young people are recognizing that "speed" is a bad drug and that heroin involves certain major risks. I think that some are also saying that LSD is something you take and maybe grow out of. And marihuana, very few of them see by their own direct experiences any significant risk at present.

If you try to develop a drug program that equates all drugs as being equally risky, you run the risk of destroying the credibility of your program and your attempt at education. They will say, "These people obviously don't know very much because they are presenting something that doesn't match with what we see every day."

Dr. Jaffe then suggested that marihuana be legalized, regulated and taxed, and tax revenue be used to finance treatment programs for hard narcotic users.

To this Co-chairman Hyde commented:

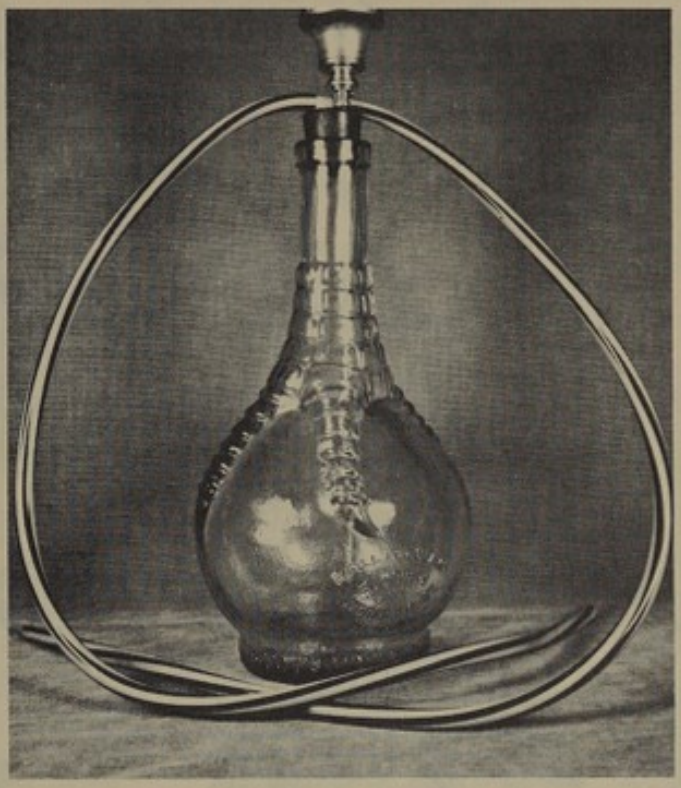
We are already stuck with the alcoholic culture. We tried to turn it back and it didn't work. Do we have to accept another inebriate, the marihuana user? Would it not double or treble the death total we now see on the highways caused by inebriates whose perception has been impaired while operating an automobile? As for me, I am just not ready to let the bars down any further. I am just frightened to death of what would happen on the highways.

The most popular brand of papers among the marihuana "in-crowd" is Bambu. This favoritism is allegedly due to the paper's slow burning qualities. Pictured above the paper boxes is a rolled marihuana cigarette or "joint".

Judge Fred G. Suria, Jr.

Judge Fred G. Suria, Jr., is the presiding judge of Narcotics Court, Chicago, Illinois. He stated that marihuana should be removed from its current position as a "narcotic" drug and placed in a separate section of the law. He felt that first offense violations should be treated as misdemeanors if the offense involved less than some arbitrary amount. This amount should not necessarily be the 2.5 grams of the present law, but the Judge declined to suggest an appropriate figure.

He urged that the present statute has proven itself unenforceable, thereby making it bad law. We do not have all the facts about marihuana, he said, but until we do we should not make felons of otherwise responsible young people. There should be no mandatory sentences. The judge should be able to handle marihuana offenses on a case-by-case basis.



Water pipes or hookahs are used for smoking marihuana and hashish. The smoke from the burning cannabis is cooled by channelling it through a liquid medium, usually water. The large glass hookah pictured above can be smoked by two persons simultaneously.

Chapter 18
CHICAGO HEARINGS: LEGISLATION, PART I

Introduction

The Commission decided to conclude its entire series of public hearings with specific observations regarding existing Illinois laws pertaining to the drug abuse problem, and to receive recommendations for remedial legislation. The fifth and sixth series were conducted in Chicago to accommodate those expert witnesses residing in the greater Chicago area. The seventh, and final, series was held in Springfield for the convenience of those expert witnesses residing in the downstate area.

In addition to government criminal justice officials, the Commission extended invitations to representatives of the major bar associations in Illinois.

This chapter will include summaries of testimony offered at our fifth series in Chicago on January 14, 1971.

Chapter 19, Part II of the legislation series of public hearings, includes summaries of testimony offered in Chicago on January 15, 1971.

Chapter 20, Part III of the legislation series of public hearings, includes summaries of testimony offered in Springfield on February 8, 1971.

Dr. Jerome H. Jaffee

Dr. Jerome H. Jaffe is the Director of the Illinois Drug Abuse Program. In his testimony he stated that the only logical way to approach the drug problem vis-a-vis legislation is first to determine the end result or societal goal of the law. In this respect, drugs should be controlled on the basis of society's concern. Primary legislative considerations should include: The damage wrought by the specific drug to citizens, whether the particular drug "causes" crime; whether its abuse results in a loss of productivity on the part of the user, and the degree to which the use of the drug alters behavior.

He said that one of the major problems encountered by drug treatment agencies is the

statutory prohibition against releasing arrest information. As a consequence, Dr. Jaffe said that rehabilitation agencies are unable to measure the effectiveness of their programs. He recommended that an official state agency be created to make regular surveys to determine the relationship between drug abuse and crime. He also urged legislation which would bar the use of voluntarily given information in criminal proceedings.

In the area of local legislation, Dr. Jaffe said that zoning reforms are needed to permit the construction of halfway houses and other drug rehabilitation facilities. He noted that it is frequently desirable to promote treatment centers which do not have "institutional" appearances.

On the subject of marihuana, Dr. Jaffe said that the present marihuana laws have not been a deterrent, and have diverted law enforcement agencies from more meritorious anti-drug activities. Moreover, he suggested that current marihuana laws criminalize large numbers of otherwise productive citizens.

He again urged the legalization of marihuana, and this brought about questions by many Commission members concerning the possible aggravating effects this would have on one already serious problem due to the abuse of alcohol. Senator Everett Laughlin and Representative Joseph Sevcik expressed concern that there is yet no acceptable scientific test which can be used to determine when a person is "under the influence" of marihuana. Unlike the breath analysis tests for alcohol, the standard tests for drugs indicate only the presence of drugs in the body, but not their concentration. Such purely qualitative tests are inappropriate for determining, for example, one's ability to drive an automobile, because small concentrations of some drugs will have no effect on driving ability. Dr. Jaffe agreed, and stated as an example persons stabilized on methadone; the drug would be detected, but there would be no adverse effect on the person's faculties.

Co-Chairman Hyde then asked Dr. Jaffe for his opinion as to what has happened since 1965 to make the drug problem flare up to such extreme proportions. Dr. Jaffe replied:

> I think a large part of it is due to the fact that at any point in time the mass media needs something to glamorize. Right now it is the whole drug scene, and we have linked the drug scene to a way of life. It happens to be a vogue, and I think, frankly, that commissions like this are part of the whole situation in which interests are focused; and people are talking about the extent of drug use and the damage it has caused. And it deserves as much attention as it gets. It is a major problem. We have glamorized it. We have made it mysterious.
>
> I think we are also caught in a kind of generation gap, where young people are seizing on the unwillingness of people to change their own traditions. It is a behavior of young people and I think that all of us went through it; looking at the older generation and looking at how inadequate they were and having our own forms of protest. I think that is part of it—I think that other parts of it are really changes in values of society as a whole.
>
> I really think that people are going to explore their environment and drugs are part of it, just as other technological things are part of it. It is one of the costs of progress. You have more stuff available and more people traveling, more communication, and they spread the way that they spread because you have young people.
>
> Now, these people are one day in New York, and the next day they are in California. I think that all you are seeing is an acceleration, what used to happen over 10 years, now happens in 10 months.

Warren K. Smoot

Mr. Warren K. Smoot is an Assistant Illinois Attorney General in Chicago. He has done considerable research in the area of drug abuse pursuant to a case pending before the Illinois Supreme Court. His testimony was an analysis of that research. He stated that Illinois now ranks as an "average" state with regard to the penalties for drug-related crimes.

He listed some of the reasons for the rapidly growing phenomenon of drug abuse, namely, experimentation, recreation, the "alleviation syndrome", sexual insecurity, defense mechanisms, and peer group pressure. He stated that ours is a drug-oriented society wherein persons are urged by the media to use drugs for quick relief of symptoms of greater underlying problems. The concept naturally carries over to encourage the use of more dangerous drugs. Marihuana has gained special popularity because it is hard to detect, is easily concealable, and purportedly has few, if any, psychological and sociological drawbacks.

Many variable factors determine the effects of marihuana on an individual. These include his physical and emotional composition, as well as

Drug abuse posters are distributed in Spanish as well as English by the National Institute of Mental Health.

his subjective mood, expectations, and surroundings. However, many adverse effects have been documented, including toxic psychosis, and "flashbacks." Often paranoid aggressive and violent behavior tendencies accompany acute marihuana intoxication.

He stated that, in general, his research indicated that marihuana is a dangerous drug which should be controlled, but perhaps possession should be a misdemeanor and the judge in any event should have extreme discretion not only to place the offender on probation but to vacate the conviction totally.

He questioned the social value of incarcerating many of the current breed of drug offenders, explaining that the three traditional purposes of imprisonment, i.e. deterrence, retribution and rehabilitation, are not served in many cases. He agreed with the following observation by Co-Chairman Hyde:

> It would seem to me that with hard narcotics, like heroin, we have to add a fourth result of incarceration to the three that you named, because again, it seems to me that the heroin user is an evangelist, and when he is out on the street he wants to make a lot more heroin users so he will feel comfortable and not be the odd-ball. And if you can immunize society from his infectious presence, that may be a regrettable thing from his point of view but a benefit from society's point of view as a result of incarceration.

Roy Kinsey and Michael Morrell

Mr. Roy Kinsey and Mr. Michael Morrell are Attorney Advisors for the U.S. Bureau of Narcotics and Dangerous Drugs, Washington, D.C. Their testimony concerned the Uniform Controlled Dangerous Substances Act, drafted by the Department of Justice to complement the new federal drug abuse legislation. They recommended that the states adopt the Uniform Act because (1) The previous Uniform Act for the states was based on federal laws repealed; and (2) There is a pressing need for uniformity among the states with regard to penalties and regulatory controls.

They explained that the Uniform Act classifies all controlled drugs into one of five schedules, each having its own criteria for drug placement. The schedules are arranged in the order of the control warranted by the drugs in each schedule. Uniformity is achieved by defining similar crimes and providing similar and complimentary regulatory controls. The offense of possession of any drug is a misdemeanor. Special provisions are made for sales to juveniles and subsequent offenses. Conditional discharge is available for possessory offenses; whereby persons charged

with their first offense may be placed on special probation, after which the charges against them would be dismissed. Conditional discharge is wholly at the discretion of the trial judge.

There is also provided a procedure for obtaining an injunction against violators to force them to cease their unlawful activities. As pointed out by Representative George W. Lindberg, the burden of proof in obtaining such an injunction would be a "preponderance of evidence," i.e., somewhat less than the "beyond a reasonable doubt" standard required in criminal prosecutions. Senator Everett Laughlin observed that there may be equal protection problems arising when some violators are enjoined while others are prosecuted criminally.

There was considerable discussion between the witnesses and the Commission members concerning the feasibility of providing for non-criminal sanctions for certain minor marihuana violations so as to avoid stigmatizing many young people with criminal records. Mr. Kinsey explained that conditional discharge accomplishes this; but perhaps offers little deterrent against the commission of these offenses. Co-Chairman Hyde offered the suggestion that some form of civil penalty might be imposed, much in the nature of the penalties for traffic violations. Mr. Kinsey suggested that this would be tantamount to legalization, and law enforcement would reduce its efforts considerably.

Judge Kenneth R. Wendt

Judge Wendt is the former Chief Judge of the Narcotics Division of the Criminal Courts, Chicago, Illinois. He commended the work of the Illinois Legislature in reducing possession of marihuana under 2.5 grams to a misdemeanor, stating that this has saved many offenders from the stigma of a felony conviction, and has produced an extremely low recidivism rate.

Mr. Siragusa made the following inquiry: "One of the phenomena that we have been looking for is the explanation for this terrible drug abuse escalation which we have witnessed during the past six years. Since you were on the court bench during that time, can you offer any suggestions or explanations as to what has accounted for this appalling increase?" Judge Wendt replied:

> Well, I can tell you that we are a pill society; we are a drug society. In fact, everyone here is a drug user, whether it be coffee or cigarettes or other drugs. I wish they would do with other drugs what they have done with cigarettes. Do you think, if the medical society knew as much about tobacco 50 years ago as they do today, that tobacco would be legalized?

He suggested that in the future, legislation should avoid using intent as an element of a crime because it is very difficult to determine in most cases. He cited as an example the provision in the proposed Uniform Controlled Dangerous Substances Act the crime of "possession with intent to sell." He also recommended the removal of marihuana from the Narcotic Drug Act and its inclusion among Dangerous Drugs.

Judge Wendt concluded by stating that a most significant step to solving the drug abuse problem lies in effective correctional and rehabilitative programs and facilities. He described many drug users as suffering from an illness, and as such need treatment more than punishment.

Senator Harris W. Fawell in commenting on the widespread use of marihuana, remarked:

> I, at one time, was a prosecutor myself between 1954 and 1957 in Du Page County, and since then have done a great deal of criminal defense work. I always have a half dozen cases or so every year, it seems, and just recently I've had a number of cases representing defendants who are charged with possession or sale of marihuana. I think the penalties are way out of reality, especially when we have so little treatment procedure and diagnostic tools available.
>
> In addition, I have noticed that a number of prosecutors' viewpoints will be if you accept a plea of possession, they don't even want you to apply for probation to even give the court the opportunity to even think about it. It seemed to me way back in 1955 through 1957 that young people were involved in primarily contributing to the delinquency of minors, liquor, or other things, and interestingly enough the vast majority of these young kids are absolutely aware of the distinction between marihuana and hard drugs.

Peter B. Bensinger

Mr. Peter Bensinger is the Director of the Illinois Department of Corrections. He stated that the Illinois Department has no specialized programs for treatment of drug addicts, although 500 persons now in the adult penitentiary system are committed for narcotic offenses. In a recent study of juvenile offenders, 53 per cent had admitted one or more experiences with

drugs. The Department intends to direct its facilities more toward correction in the future and is opening its first drug abuse community-based program in Chicago at the end of Spring, 1971. It will handle parolees and work release inmates in residency, and will include counseling and a specialized effort at preventing a return to drug abuse. This program will be funded by a $200,000 grant from the Illinois Department of Law Enforcement.

On the subject of the causes for youth's involvement with drugs, Representative George W. Lindberg asked the following question:

> I have had some experience in talking to people who were involved in the commission of a crime, of violations of the criminal laws, and I have found that these people, in my opinion, have long been neglected as a source of information on how to cope with the very problems that have caused them to be incarcerated. Have you made any attempt with regard to drug abuse, or generally within your system, to ascertain from your inmates what they feel would have been successful in restraining them from getting involved in drugs, or other crimes?

Mr. Bensinger offered this answer:

> I can answer that subjectively in the sense that I think two factors are largely responsible for the kids' being in trouble. First, parents are relatively unknowledgeable. In fact, they are not familiar with the answers to the questions juveniles put to them. I have found that the questions parents ask don't make sense chemically or any other way.
>
> The other major concern, that I think is a factor, is that we are not providing a curriculum on drugs on a uniform, statewide basis, and this is something I think we should do. I think that we should insist that the State Superintendent of Public Instruction make drug education a part of the curriculum.

Mr. Bensinger completed his testimony by stating that if marihuana is shown to have a social use, it should be taken off the books entirely, and the law should concern itself only with the abuse of the drugs. That is, the law should direct itself only to the social misconduct which arises from drug abuse rather than the mere administraiton of the drug itself. This suggested plan would be comparable to the present law relating to the use of alcohol.

Chapter 19
CHICAGO HEARINGS: LEGISLATION, PART II

Thomas P. Sullivan

Mr. Thomas P. Sullivan is a Chicago attorney of the firm Jenner and Block, and is considered one of the foremost criminal attorneys in the State of Illinois. He has researched the area of narcotics and drug abuse legislation in conjunction with a pending case, wherein he challenges the constitutionality of the Illinois drug laws. His position in this case is the following: The Illinois statutes establish two categories of controlled drugs, namely "narcotics" and "synthetic" drugs. Marihuana is classified as a narcotic. Punishment for drug offenses is a maximum one year for "synthetic" drugs and a minimum 10 years for "narcotic" drugs. He claimed there is unanimous agreement that marihuana is non-narcotic and there is considerable evidence that it is no more dangerous than the "synthetic" drugs, such as LSD. Therefore, Mr. Sullivan contends, it is denial of equal protection for the state to punish for the sale of marihuana far more severely than it punishes for the sale of more dangerous synthetic drugs. Further the minimum mandatory 10 year sentence constitutes cruel and unusual punishment.

He suggested that the Illinois drug laws be revised to reflect current scientific knowledge about controlled substances and to be flexible enough to accommodate future knowledge and information. A distinction should also be drawn to differentiate a true "sale" from a casual distribution. Judges should be given great sentencing discretion to avoid unwarranted harshness in penalties. He also claimed that in marihuana cases, the penalty could be based on the amount involved in each case.

Gerald W. Getty

Mr. Gerald Getty is the Public Defender of Cook County, Illinois. From his experience with persons charged with drug offenses, he suggested that the drug laws be changed to allow probation for drug offenders, to direct the efforts of law enforcement toward the large-scale pushers and manufacturers of drugs, to expand

a judge's sentencing discretion, and to reduce the maximum penalties for the lesser drug offenses.

He reported that statistics for the First Municipal District showed 10,984 drug charges in 1968, 11,953 in 1969, and 17,811 in 1970. The Public Defender's Office represents 40 per cent of these persons charged with drug violations, as compared with 50-55 per cent representation for crimes in general. This indicates in his opinion, that more drug violators are able to afford their own lawyers. Many of the users, in his opinion, come from middle to high-income families and have more money available to them than those from the ghettos.

On the subject of civil commitment of addicts, Senator Everett Laughlin posed the following question:

> From the standpoint of your experience, do you think that there would be any purpose served by legislation which would provide for the commitment of addicts to a proper state institution, rather than criminal prosecution? In other words, to have an addict committed and treated in a state facility designed to help him and take him out of society for a limited period of time? Is this a desirable thing?

Mr. Getty replied:

> Sure, it is desirable, if you have the money to do it. What we are talking about is the addict who is really hooked and is on some kind of hard narcotic drug. If there is some medical way that he can be treated so that he will not have to go back to his addiction, then this would be a worthwhile undertaking.

Mr. Getty said that of the 10,984 persons charged in 1968, there were only 771 indictments. Judges and prosecutors will often reduce sales offenses to simple possession. They realize that the offenders in many cases are not true "pushers" and do not deserve a term of 10 years to life. He suggested that revision of the laws is necessary to make penalties more commensurate with the offense, and to place more emphasis on the profiteering traffickers in drugs.

Edward T. Scholl

Mr. Edward T. Scholl is the Alderman of the 41st Ward of the City of Chicago. In his testimony he emphasized the need for a co-ordinated drug abuse education program for young people, beginning at the fourth grade level. This program is needed, in part, to counteract the poor example set by the adult generation by its dependency and abuse of other drugs, such as tranquilizers and alcohol, which are glamorized and advertized by the mass media.

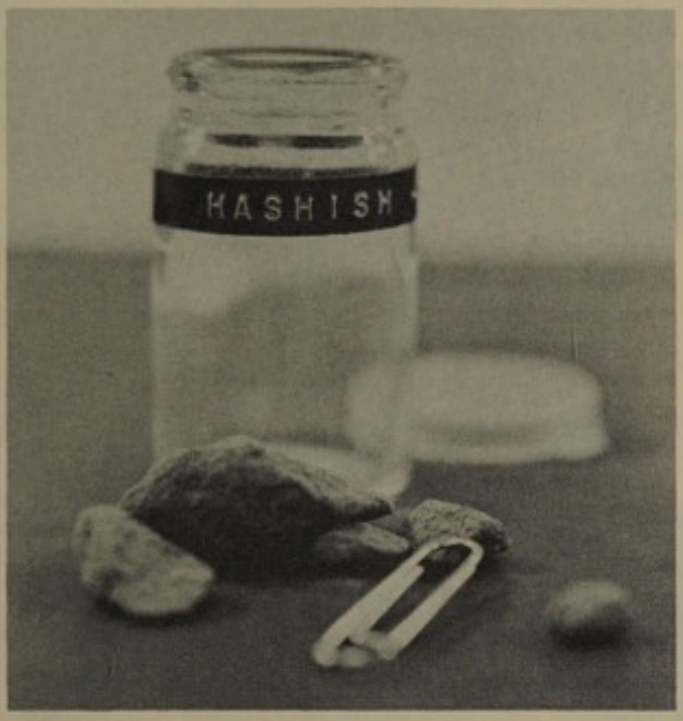
Mr. Scholl urged closer coordination between state and federal drug laws, the expedition of the judicial process for drug offenses, and the enlargement of educational and rehabilitative efforts in this area. In particular, he recommended that the laws and law enforcement facilities of the state be revised and improved in order to meet severe penalties and swift justice upon the commercial traffickers of drugs.

He also suggested that in addition to a statewide educational program, youth commissions be established to counsel and oversee young drug offenders. He approved of the mandatory notification of parents of all drug offenders under age 21, and to this Co-Chairman Hyde commented: "This is a good suggestion and is something we ought to look into. The parents, who are supplying their children with a car and an allowance, have available some sanctions, and these may be the most effective sanctions."

David Blumenfeld

Mr. David Blumenfeld is the Pharmacy Coordinator of the Illinois Department of Registration and Education. As such, he is the Chief Law Enforcement Officer of the Pharmacy Practice Act. His office cooperates with the Federal Bureau of Narcotics and Dangerous Drugs by investigating complaints and collecting intelligence data.

Mr. Blumenfeld explained that there currently exists a substantial problem in the diversion



Small chunks of solid hashish, a condensed form of marihuana, are prepared from cannabis resin. It is usually shipped in large bricks to dealers who then break it into smaller lumps as shown.

of drugs into illicit channels. He said that one point of diversion is the physician who indiscriminately prescribes drugs for patients without determining a legitimate medical need for those drugs. Under current Illinois law there is no provision prescribing this sort of activity. In fact, there have been instances where persons have obtained prescriptions on Public Aid forms, so that the state actually pays for their illegal supplies of drugs. Another point of diversion is theft from manufacturers' premises, largely due to inadequate security measures.

He stated that the new federal drug law provides federal officials with the means to regulate the legal flow of drugs, but that state control must be relied upon due to the shortage of federal personnel. He would support Illinois legislation complementary to the Federal Act.

Ellis Reid

Mr. Ellis Reid is the President of the Cook County Bar Association, Chicago, Illinois. He said that the thrust of the state's efforts in fighting the drug abuse problem should be directed at two points: (1) Comprehensive education of all the citizens on the nature of the problem and (2) A commitment to the concept that drug abuse is more a medical problem than a criminal problem.

He urged that more attention be given to developing communication with young people and instilling in them a resistance to the peer group pressure which would have them turn to drug abuse. He suggested that the traffic in drugs could be more effectively combatted by legalizing all drugs and thereby removing the profit motive to sell drugs illegally.

Mr. Reid is associated with Operation Crossroads, which is affiliated with the Better Boys Foundation. Mr. Reid stated that Operation Crossroads was organized in response to the growing drug abuse situation among Chicago's youth. The program is designed to assist young persons in resisting peer group pressure to use drugs. The general philosophy of the program is that the use of drugs represents escapism. Mr. Reid also spoke highly of the Farragut Outpost. This organization offers accredited courses for high school dropouts. Many of the courses offered are designed to instill a resistance among the students to experimentation with drugs.

Chapter 20
SPRINGFIELD HEARINGS: LEGISLATION, PART III

Reps. John Merlo and Arthur A. Telcser

(Presentation by David Epstein)

Representatives John Merlo and Arthur A. Telcser were co-sponsors of legislation providing for the revision of penalties for the possession and sale of marihuana and other dangerous drugs. Under these bills, marihuana would be removed from the Illinois Narcotic Drug Act and included in a new Drug Abuse Control Act, which would replace the old Drug Abuse Control Act of 1967. In effect, these bills would re-classify marihuana as a non-narcotic, and increase the penalties for the sale and possession of the amphetamines, barbiturates and psychedelic drugs.

Presenting the views of Representatives Merlo and Telcser was Mr. David Epstein, Administrative Assistant to the Minority Leader, Illinois House of Representatives. Mr. Epstein emphasized that under the present laws, first offenses involving sales of marihuana are penalized by imprisonment for 10 years to life imprisonment, while sales of other non-narcotic but dangerous drugs like barbiturates, amphetamines and psychedelics (i.e. LSD) are only misdemeanors.

He said that this destroys the credibility of the law for many young people, and, in his opinion, may encourage them to experiment with the highly toxic drugs. In his view this results from the fact that nearly all young persons have either used marihuana or have at least known someone who has. They claim that to their knowledge they have neither experienced nor observed any highly deleterious effects. They then conclude, according to Mr. Epstein, that if heroin, for instance, is in the same category under the law, as marihuana, it must be equally safe to use.

Mr. Epstein explained that a suggestion by Superintendent Mitchell Ware of the Illinois Bureau of Investigation to provide that possession of large amounts of drugs would be penalized similar to sales, was not encompassed

in the pending bills but was under consideration for future addition. This would relieve prosecutors of the task of proving an intent to sell. Such a provision would have to be based on amount standards which would realistically delineate between the commercial traffickers and the petty sellers.

Mr. Epstein supported the continued use of a "weight standard" for future penalty classifications for marihuana violations.

John Paul Davis

Mr. John Paul Davis is the Legal Assistant to the Chancellor of Southern Illinois University, Edwardsville, Illinois who testified as a member of the Madison County Bar Association, to whom we addressed our original invitation.

He testified that as a minimum proposal, he would favor removing marihuana from its classification as a narcotic drug and adding it to the Drug Abuse Control Act of the Public Health Code. Ultimately, however, he would strongly favor the complete legalization of marihuana.

In support of legalization he gave the following reasons: First, marihuana is readily available to virtually everyone in the illegal market. "Prohibition" has proven ineffective. Some estimates allege that 20 million Americans have at least tried it.

Senator Cecil Partee questioned Mr. Davis as to whether he, in his research, could discern any correlation or similarities between the defunct alcohol prohibition laws and current laws which prohibit the use of marihuana. Mr. Davis replied:

> I think there is a very apparent parallel between prohibition of marihuana in 1971 and the prohibition of alcohol use and possession in the 1920's; and I think the crux of the parallel is simply that while the state maintains and certainly has the legitimate authority to regulate social conduct, there are certain things which individuals may produce themselves and are easily transportable, with the result that the state is simply not capable of enforcing their prohibition.

Senator Hudson R. Sours inquired whether Mr. Davis subscribed to the view that marihuana tends to lead the user to "hard" drugs. Mr. Davis responded:

> While it is true that if you go to the federal narcotic facility at Lexington and study the persons committed there you might find that a very high percentage of persons addicted to heroin started on marihuana, the converse of that is not true. It has never been substantiated and there is no reliable evidence whatsoever in support of the proposition that a majority of persons who utilize marihuana go on to harder drugs.

Mr. Davis said that the second reason for the legalization of marihuana was that the substance is non-addictive and, therefore, it does not drive users to commit crimes to support their "habit." In addition, he thought that prohibition of marihuana could actually encourage more serious crimes because it drives the underground price upward and, under current law, makes the legal risk for using heroin no greater than the use of marihuana.

In conjunction with the legalization of marihuana, Mr. Davis recommended the establishment of a state monopoly over the processing, packaging, and sale of the drug. He contended that this would assure users of a standardized, sanitary and unadulterated product. Mr. Davis holds the highly debatable view that "legalization of marihuana would produce no change in the current degree of usage." He further stated that he would place no minimum age restrictions on marihuana use if it were legalized. He said that this was an area which was better left to parental responsibility, to which Senator Sours commented:

> That's the trouble today. Most parents in many families have to work to survive, not to accumulate property, but to survive. The parents are often no longer in a position to exercise their authority.

Mr. Davis replied:

> Well, again I think my position would be that imposing an age limitation would obviously be an arbitrary judgment, and there may be some value in doing that, but I think that the value in not doing it would be controlling because I'm posing that it would create more problems in enforcement and would degrade from the intent of liberalizing the statute in such a way that it would counterbalance any value obtained by imposing the age limit.

Concerning LSD and the psychedelics Mr. Davis suggested that the maximum penalty should be no greater than one year. Also, if further research discloses no substantial risk in the use of "relatively small doses," he would recommend the legalization of LSD. He said that LSD can be manufactured easily in the home, and perhaps its greatest danger lies in the uncertainty of the potency of the doses one takes.

Mr. Davis thinks that heroin should be controlled much more stringently than marihuana or LSD because it is addictive and leads to physical and mental deterioration. He recommended that state funds be appropriated to establish facilities which would administer methadone or some related therapeutic substance. By doing this on a sufficiently large scale, he claimed the state could eliminate the profits now reaped in the underground traffic in narcotics, prevent the crime incident to supporting an addict's habit, and provide the addict with a legal alternative to continually supporting the underworld's illegal monopoly in heroin traffic. He dramatized the tremendous impact of the traffic in narcotics on society by pointing out that it costs an addict up to $60 per day to support his habit. According to Mr. Davis there are over 10,000 addicts in Illinois alone. He stated that this amounts to a staggering yearly figure of $219 million worth of narcotics which addicts must obtain, largely through theft.

(Many members of the Commission disagreed with many of Mr. Davis' views and observations.)

Paul Riley

Mr. Paul Riley is a practising attorney in Edwardsville, Illinois, a Public Defender in Madison County, and testified as a representative of the Madison County Bar Association. His testimony concerned the penalties provisions in the present Illinois law for the sale of narcotic drugs. He said that the 10 year minimum, mandatory sentence was probably intended to deter those persons who are heavy traffickers in drugs. However, it also applies, unfairly, in his opinion, to anyone remotely connected with a sale of narcotics. He thinks it is unwise to remove discretion from the trial judge. In his view, probation should be permitted in all drug cases; including both sale and possession.

He deplored the lack of adequate facilities in the state to treat and rehabilitate drug addicts. Mr. Riley suggested that Illinois might borrow from the Sexually Dangerous Persons Act for committment of hard narcotic addicts. Lastly, he favored the retention of heavy penalties for sales of substantial amounts of drugs.

Richard Hollis

Mr. Richard Hollis is the State's Attorney for Sangamon County in Springfield, Illinois. Mr. Hollis was unable to appear, and Mr. Arthur Inman, Assistant State's Attorney testified in his behalf.

Mr. Inman testified that there are a number of cases which uphold the practice of designating marihuana as a narcotic drug, even though that is not chemically accurate. In these cases the courts have held that any such classification is a reasonable method of legislative regulation in the interest of public health, safety and welfare. He suggested that marihuana be classified as a hallucinogenic drug, like LSD, and that the Drug Abuse Control Act be amended to make felonious the first or second offense of selling hallucinogens.

In his opinion the penalty should be a minimum of one year and a maximum commensurate with the offense. Possession should be a misdemeanor for first offenses involving small amounts, and a felony for subsequent offenses or possession of large amounts. He condemned the minimum 10 year sentence now provided in the Narcotic Drug Act, stating that probation should be allowed in all cases.

He said that according to the current thinking of penologists and criminologists, the mandatory 10 year sentence is adverse to the chances of rehabilitation while in prison. There should be a three-to-one relation between the maximum and minimum sentences, according to Mr. Inman.


WILL THEY TURN
YOU ON
OR WILL THEY
TURN ON YOU

Chapter 21
CONCLUSIONS

It is the Commission's conclusion that there is no greater problem confronting the State of Illinois today than that of drug abuse. Indeed, it has, in our opinion, reached crisis proportions. In the course of our investigation we have analyzed virtually all of the disciplines and great issues involved in the problem. The conclusions below represent a summary of our findings.

Legislation

1. Many drug offenders have no other type of convictions in their criminal records, and pose no other demonstrable risks to society. They include addict users, marihuana smokers and sellers of small quantities of marihuana. These persons, upon conviction for first offenses, are entitled to leniency and should not suffer from the permanent stigma of a criminal record. Judges should have the opportunity to grant conditional discharges to persons in these categories and expunge such arrests from their records.

2. In terms of relative damage to society, the commercial drug seller is substantially more odious than the addict user. Drug control laws should reflect this distinction by providing appropriately strong deterrents against sales and distribution offenses.

3. Drug control laws should be predicated on the danger to society posed by each of the various drugs. This difference lies in the drug's potential for abuse, its role in therapeutic medicine, its toxic effects on the user, and its ability to produce physical or psychological dependence. These standards necessitate the classification of controlled drugs on the basis of their inherent properties rather than on a generic distinction between narcotic and non-narcotic drugs.

4. In an attempt to keep a closer surveillance on the progress of persons paroled after

having committed drug-related crimes, the law should provide that chemical detection tests be performed periodically on these persons in order to determine whether or not they have reverted to drug abuse.

5. One of the most heinous of the drug-related crimes is the sale of dangerous drugs to children. Special provisions must be included in the law to reflect society's repulsion for this type of conduct in the form of substantially increased penalties.

6. Laws which treat marihuana with the same degree of severity as heroin or other extremely dangerous substances fail to accomplish adequate control. Harsh minimum mandatory sentences will be circumvented by prosecutors, judges and juries to the extent that there is no meaningful legal sanction to marihuana use. It is essential that the law be flexible to meet the contingent circumstances of each case.

Regulation of Legitimate Trade

1. The broadcast media would do well to adopt a program of self-discipline in the area of excessive drug advertising. Our society has become drug-saturated by such advertising to a degree where people look to drugs to solve even minor physical or emotional problems.

2. An effective regulatory system for the legitimate drug trade is essential for a meaningful endeavor against drug abuse. Each level of distribution must maintain strict standards of security, accountability, and responsibility. These duties must include even those who deal in small amounts of dangerous drugs, such as physicians and pharmacists.

3. Many adults without a prior history of drug abuse have found themselves unwittingly dependent on barbiturates and amphetamines through the indiscriminate or unscrupulous prescription of these drugs. This is particularly true in the case of amphetamine dependence as a consequence of overprescription in weight loss programs. Those physicians who are responsible for excessive prescriptions of these drugs should substitute a more cautious diet regimen which does not include powerful stimulants. Those who knowingly and unscrupulously prescribe these drugs solely for the profit should be censured by the medical profession.

4. Illinois is one of the country's largest manufacturers of drugs that are abused, particularly the barbiturates and amphetamines. Therefore, these manufacturers have special responsibilities. Thefts of these drugs from manufacturers' premises are admittedly infrequent but are sufficiently serious to warrant the strengthening of existing security safeguards where such crimes have been committed and to institute proper preventative practices in those manufacturing plants that have not as yet been victimized.

The new Federal Dangerous Substances Law, effective May 1, 1971, empowers the United States Attorney General to cut off the flow of manufactured drugs to foreign countries when shipments exceed the reasonable medical needs of those countries. This reflects the fact that American manufacturers, including those in Illinois, are prone to excessive production. In that regard, a policy of self-discipline to prevent over production would seem to be warranted.

Some dangerous substance manufacturers are inclined toward advertising in medical and other trade journals that exaggerates the therapeutic values of new drugs without providing accompanying admonitions concerning their toxicity and other harmful characteristics.

Specific Drug Phenomena

1. Drug abuse has acquired the characteristics of a subculture within our society. Members of this subculture have developed their own language, morals, and behavior patterns. Drugs are often seen as a device for expressing rejection of traditional American values. Drug abuse is no longer primarily a ghetto problem. The drug subculture extends to every stratum of American society.

There is a growing trend of drug abuse in Illinois which is reaching out into drugs of all descriptions. Dangerous drugs such as amphetamines and barbiturates are being consumed in incredible volumes. The growing acceptance of cocaine is a particularly alarming trend. Experimentation with psychedelics, such as LSD, bode disaster for our youth.

2. Addiction to heroin is the most serious drug abuse problem in Illinois today. The increase in deaths caused by overdoses of barbiturates indicates that the abuse of depressants

is the second most serious problem. The injection of methamphetamine, commonly known as "speed", is a particularly dangerous practice and appears to be on the increase.

The infamous "pusher" of years past is now only a memory in most non-narcotic drug sales. Indeed, even the deplored *heroin* pusher may be "the boy next door" or the pretty teenage girl who lives down the street. Today, in most cases, sales of drugs are made by persons who are also users.

The high level traffickers who make substantial profits from other persons' miseries continue to thrive—unseen but ever present.

In this regard there is an international network of manufacturers and suppliers of narcotics and dangerous drugs. Regular channels of illicit drug commerce have been set up and continue to be operated by the forces of organized crime.

3. New York has the largest drug problem of any state in the nation, followed closely by California. For reasons not yet established, Illinois seems to follow California drug abuse patterns in terms of time sequence. Currently, marihuana usage in California seems to have peaked with a concomitant and noticeable increase in heroin addiction. Although there is no scientific evidence that marihuana use leads to heroin addiction, this transistory manifestation has definately occurred in the changing subculture. It is reasonable to assume that once again Illinois may mirror this same trend.

The prevalence of heroin addiction among American military personnel in Viet Nam is an additional item of concern. With the return of addicted Illinois veterans, many will not be completely cured when they resume their civilian life. We can reasonably expect our heroin addict population to increase.

4. The drug crisis in today's society has naturally carried over to business and industry. Employees who have become involved in drug abuse are a significant risk to the safety of other employees and to the welfare of their employer's business.

Youth Involvement

1. Young people account for the majority of drug abusers in Illinois. One or more of the following factors are responsible for this phenomenon: peer group pressure, fashionableness, rebellion against an imagined rootless society, the Viet Nam War, the monotony of life, worry, a desire to escape tension, a desire to shock parents, curiosity, despair, apathy, and the desire to achieve "true" potential. With regard to the psychedelic drugs there is often another reason; the search for imaginary revelations and new religious experiences, and an urge to find new forms of creativity.

2. Although permissiveness and irresponsibility have often been cited as the causes of drug abuse in the young generation, a factor which is too infrequently recognized is the failing of parents to give proper inspiration and direction to their children. Members of adult society are often so engrossed with improving their own economic and social status that they neglect their traditional responsibilities toward the welfare of their children, such as keeping a careful watch on their personal habits, and the company they keep. They also fail to be on the alert for the tell-tale signs of drug abuse, dismissing as inconceivable the proposition that their own children might be involved.

Parents contribute to the drug problem in other ways, too. For instance, many young people need look no farther than the family medicine cabinets for a ready supply of stimulants and depressants purchased by their parents to "help them through the day" and then get them to sleep at night. Parents should limit their purchases of drugs to those absolutely essential to the health of the family, and then keep those under careful observation.

Excessive drinking, immorality and other permissive adult practices destroy the credibility of admonitions to practice temperance. The young are quick to recognize hypocrites, and will ignore their warnings and gratuitous advice.

3. The proliferation of the drug abuse problem parallels the proliferation of drug articles in underground newspapers. While there may be legitimate disagreements as to whether such articles are a cause or an effect of the drug subculture, we believe that certain aspects of this particular news medium are disconcerting.

We acknowledge that there has been strong advocacy for the legalization of marihuana in underground newspapers. We consider this to be a legitimate dissent that should be heard in any dialogue seeking to affect legislative change. However, we must look with disfavor upon those

articles which directly or inferentially glorify the use of hard drugs and the hallucinogens. Some of these underground newspapers have published the names and addresses of narcotic enforcement officers and the identifying details of official government vehicles. We believe this is deplorable.

Some newspapers list prevailing prices for all dangerous substances, including the hard drugs. This can only be construed to be helpful to illicit drug purchasers in encouraging them to continue drug consumption by finding the best "bargain." Still other underground newspapers attempt to draw distinctions between "good" and "bad" psychedelic drugs, often identifying particularly toxic drugs which have been purposely mislabeled, and the names of the pushers guilty of these deceptive practices. This practice may be slightly mitigating in terms of alerting users to especially harmful substances, but it implicitly encourages the perpetuation of drug dependency.

4. There is no evidence of a causal relationship between rock music and the decision of young people to use drugs. However, it is likely that drug-oriented rock music creates an atmosphere of acceptability for drug use. Often the lyrics of popular songs advocate or are highly suggestive of the pleasures of drug use. Further, the musical form is often intended to duplicate the sensations of an "acid trip." The personal lives of many leading folk and rock performers have had a significant impact on the life styles of many American youths. These performers have become modern heroes and are often emulated by their young audiences. They have become increasingly vociferous in expounding their political and religious philosophies and often advocate drug abuse either by words or actions.

5. There is a notorious and amply demonstrated relationship between rock festivals and drug abuse. These festivals provide a gathering place for members of the counter-culture where drugs can be used and traditional sexual mores ignored with abandon. Performers often actively encourage drug abuse through their lyrics and demeanor. The festivals have also been punctuated by incidents of violence perpetrated by members of various motorcycle gangs. It is often impossible for law enforcement officers to make arrests for violations of the drug laws because they fear for their personal safety and seek to avoid destruction of the neighboring small communities.

6. The proliferation of "head shops" in metropolitan areas and in the vicinity of secondary schools and colleges is a source of concern. We do not fault the retail sale of items of musical and wearing apparel interest for the hippie subculture. However, we view the flagrant sale of paraphernalia used exclusively to smoke marihuana and to enhance the "highs" of other drugs with dismay since it is an indication of the widespread acceptance of drug use among our youth.

Marihuana

1. Rather than assume marihuana to be the most significant factor in the escalation to opiate addiction, we think it more likely that introduction into the drug subculture, with its emphasis on drug experimentation, is the most influential factor. Yet it must be admitted that a person who does not start with one of the milder drugs is not likely to become involved with the stronger ones.

Marihuana is an unusually dangerous drug—particularly when used regularly. Although it is not addicting and does not "cause crime," it is extremely hazardous to one's health and should not be legalized.

To argue that alcohol and tobacco present comparable health hazards is no argument for legalization. The mistakes of the past are no rationale for an error of even greater consequence in the present.

2. There is an appalling prevalence of wild marihuana growth in Illinois, particularly in rural or agricultural areas. Although most of the marihuana appearing in the illicit traffic is of Mexican and other foreign origin, uncultivated marihuana has been seized often enough in Illinois to make it a matter of serious concern.

Farmers are primarily responsible for the fact that the destruction and eradication of wild marihuana fields has not been sufficiently effective. The Illinois Department of Agriculture and the Illinois Department of Law Enforcement have demonstrated excellent capabilities for chemical destruction of these noxious weeds, but because of the huge agricultural areas in Illinois it is impossible for those departments to search out all the areas of wild marihuana growth. They have to depend upon detection and voluntary reporting to the authorities. Farmers have been woefully lax in that regard.

Law Enforcement

1. There is substantial evidence that the efforts of law enforcement agencies related to the drug laws have been misdirected toward the lowest echelons in the drug distribution system. The majority of drug-related arrests have involved drug users who happen to also be sellers. Consequently, a very small portion of the illegal drugs smuggled or manufactured in this country is confisticated or otherwise removed from the illicit market. It is the responsibility of police administrators to direct their efforts toward higher levels of distribution.

2. The gross proportions of the drug problem in Illinois have created ancillary problems in the judicial procedures related to drug offenders. One such problem is the often unjust delay resulting from inadequate laboratory facilities which are necessary to determine if substances sold or possessed by defendants are actually illegal drugs. At one time this delay amounted to nearly eight weeks of incarceration for persons who were arrested under the drug laws but were too poor to produce bail. Recent actions by some judges and police administrators have reduced this delay to approximately three weeks; but this is still an undesirable and intolerable situation.

3. Law enforcement has not imposed an appreciable increase in risk to suppliers and traffickers in illegal drugs. This has been manifest by the fact that the price for heroin has remained relatively constant during the past decade. In fact, when inflation is taken into account, the price of heroin has actually decreased in terms of market value.

4. The suppression of the interstate and international illicit drug traffic is the responsibility of the United States Bureau of Narcotics and Dangerous Drugs. Despite the very large seizures of contraband drugs in interstate commerce and the even larger seizures abroad by federal agents in conjunction with foreign police, illicit drugs continue to pour into this country. Much of this regrettable situation is attributable to the lack of proper measures by source countries to stem this flow.

The suppression of the intrastate and local illicit traffic in Illinois, as in all states, is the primary function of municipal, county and state law enforcement agencies. Although strides have been made in drug enforcement in Illinois, a substantial need for improvement is still indicated. Most of the violators are either apprehended for possession of small quantities of drugs for their own consumption or for so-called "accommodation sales" of small packets to other users. The intermediate and major sources of supply are too infrequently apprehended with the result that no appreciable impact is made toward the elimination of sources of supply.

5. More persons are arrested in Cook County for violation of the drug laws than in all the other Illinois counties combined. This fact undoubtedly reflects prevailing patterns. The two narcotic courts in Cook County are over-burdened with a daily load of about 400 drug cases, causing unnecessary delays in adjudication and overcrowding of the jail with defendants awaiting trial.

6. Law enforcement efforts against drug abuse can be greatly facilitated if they enjoy broad citizen support. Activities by citizen groups, such as A.I.D.S., which supplies information to the police concerning suspected drug violations, are commendable for their fervor and commitment in the fight against narcotics and dangerous drugs.

Treatment

1. The "British System" approach to the drug problem would be singularly inappropriate for conditions prevalent in the United States today. It has been indicated that the drug problem in the United States is more than 20 times the problem in Great Britain. The wholesale distribution of narcotic drugs to addicts by government clinics or by private physicians is likely to multiply the current crisis.

2. Methadone maintenance appears to be the most practical treatment approach for poorly motivated or hard-core heroin addicts. Methadone programs have proven their value in allowing once hopelessly addicted persons to lead relatively normal and productive lives. Methadone, like heroin, is a narcotic drug and is itself addicting. If injected, it produces a similar state of euphoria. Therefore, methadone maintenance programs must include rigid security measures against diversion, regular and periodic chemical tests to determine if the patient has been taking other drugs, and collateral services, such as legal, psychiatric, and vocational services, in order to insure total rehabilitation.

3. The therapeutic community approach to drug treatment has only a limited appeal. Its

success is usually restricted to highly motivated persons who are not considered hard-core addicts. The drop out rate is high, sometimes exceeding 80 per cent of those who begin treatment. However, it has been found that the therapeutic community is often the most successful modality for those types of patients with substantial ego development who are responsive to this approach.

4. Just as methadone has become a significant tool in the treatment of narcotic addiction, there is a pressing need for the discovery of a similar substance which can be utilized in chemotherapy for addiction to non-narcotic drugs, especially the barbiturates. Outside of therapeutic communities and individual counseling there are currently no proven treatment modalities for non-narcotic drug dependencies.

5. The involuntary civil commitment of drug addicts is often the only available means to insure their participation in treatment and rehabilitation efforts. The civil commitment statute in Illinois has rarely been used and is likely to be held unconstitutional if challenged in an adversary proceeding. It fails to provide the many constitutional safeguards which have been demanded of similar statutes in other states.

6. Drug abuse treatment and rehabilitation facilities in Illinois are inadequate for the number of persons requiring professional help. Currently, the Illinois Drug Abuse Program of the Department of Mental Health lacks the physical and financial capacity to accept even all the addicts referred to it by the courts in connection with criminal convictions. There is a backlog of addicts awaiting admission for treatment numbering in the thousands.

As indicated above, Illinois law currently provides for the civil commitment of drug dependent persons. However, there have been very few referrals under the statute to the Illinois Drug Abuse Program. Aside from constitutional considerations the reason for this non-use of the commitment statute is obvious; the program is not equipped to offer treatment services to all potential patients.

The Illinois Drug Abuse Program makes the determination as to which of the treatment modalities an addict is referred: government facility, private facility, or ambulatory treatment. To our knowledge there has been a lack of continuing evaluation to determine which modalities have been most efficacious.

7. The Illinois Drug Abuse Program has received nationwide favorable recognition for its concept that no one modality for treatment and rehabilitation can be successfully applied to every heroin addict, and that testing and evaluation must be necessary prerequisites to arrive at an accurate modality selection. The Commission concurs with this fundamental concept of treatment.

Despite the accuracy of this concept, current testing and evaluation procedures are lacking in scientific precision. Inherent procedural difficulties are the lack of sufficient trained personnel to handle a backlog of several thousand addict applications, and the high degree of subjectivity in making correct determinations.

8. One of the major impediments to offering full treatment and rehabilitation services to all drug dependent persons in Illinois is the lack of qualified personnel to operate expanded facilities. It has been the experience of many treatment programs that trained personnel are lured away by other programs which are able to offer higher salaries or more prestigious positions. Ironically, Illinois has lost the services of its nationally known director of the Drug Abuse Program, Dr. Jerome Jaffe, by his appointment to a federal position by President Nixon.

9. Community centered private drug treatment and rehabilitation centers serve a necessary and valuable function. The Illinois Drug Abuse Program refers many addicts to some of these centers and partially subsidizes them. However, there are also a few private centers that employ questionable practices. In others, the profit motive seems to be the overriding consideration. Although their facilities are not used or financed by the Illinois Drug Abuse Program, government licensing and regulation of these centers is warranted.

10. A significant ray of hope, in relation to the proliferating drug abuse problem, exists with the advent of a new religious movement. Some teenagers and young adults erroneously rationalize that drugs are an escape from a rootless society. Others mistakenly believe that religious revelations can be experienced through the use of drugs, particularly the psychedelics. In many instances religiously-motivated persons have proven to be extremely effective in convincing youths to reject drugs and assume productive roles in society. We hope their zeal will not flag and that their important work will continue to restore the youthful victims of drugs to meaningful positions in the community.

Education

1. The dilemma of whether or not to tell children about drugs no longer exists. We have witnessed too well the results of avoiding the subject. The problem now facing us is what to tell them and how to tell them about drugs. Care must be taken to ensure that drug information is accurate, that it is presented in a form that is understandable by the age group to which it is directed, and that it does not simply arouse the curiosity among children to use drugs and become no more than a technical manual for drug abuse.

2. Long-range educational goals must include the creation of an awareness in our society of the problem of chemical dependence of all kinds. Drug abuse is only another aspect of the pervasive effects of chemicals in our lives. Chemicals process our food and water, but they also contaminate our air, water and soil. The headlong rush of technology has often brought progress, but because of a lack of circumspection, has failed to provide solutions for many resultant problems, such as pollution or drug dependence. The dangers and liabilities of chemically tampering with the natural state must be recognized before scientific innovations can be utilized wisely and intelligently.

3. The enlightened approach to drug education must assume that when armed with the facts on all sides of an issue, a young person will act in a way which is responsible to his sense of personal well-being and preservation. "Scare techniques" or exaggerated accounts of the hazards of drug abuse will be totally discredited and ignored, making rumor the guiding force. The only credible approach is to present facts, whether or not they all tend to discourage drug abuse, and allow each individual to make his own decision. Educational efforts will seem unreal unless the facts presented fit into the reality seen and experienced by the students.

4. Research shows that the ages of children most in need of drug education and most curious about the effects of drugs on man are the fourth, fifth, and sixth grade levels. The ideal program would provide relevant presentations to students from kindergarten through the twelfth grade level.

5. Facts concerning drug abuse may be presented subtly by incorporating references to the effects of drugs in collaterally related courses, such as history or biology.

6. Educational approaches and methods must be designed to convey an accurate message on the dangers of drug abuse while circumventing the obstacles which make students unreceptive to conventional teaching methods. Students often appoach the educator with preconceived theories about drugs, derived mostly through rumor, and are nearly universally affected by a "credibility gap" which has developed through previous hypocritical or blatantly erroneous education efforts.

7. Drug abuse education in Illinois today is mandatory under law, but the implementation of drug education courses is the responsibility of individual school directors, and curricula vary between schools. There is no requirement to meet quality standards or to include vital subjects. There is no uniformity to education approaches.

8. Educators in most Illinois schools, from kindergarten through college, are woefully equipped in the area of drug abuse knowledge simply because they have not received sufficient training themselves. What meager training they do receive is usually within the framework of a few courses in sociology and psychology, or from lectures by guests from the various drug-related disciplines—most frequently from the criminal justice area. Given the complexity of the drug problem generally, and the many interacting disciplines specifically, this narrow preparation is inadequate. This lack of preparatory training is reflected in most primary and secondary schools in the state.

9. Drug abuse education in most Illinois schools is inadequate, fragmented, and improperly structured. Teachers are not sufficiently equipped with essential knowledge concerning the drug abuse problem. Under Illinois law, drug education courses are required in all state supported schools as a prerequisite to graduation. However, to our knowledge this statutory provision has not been implemented.

The determination to establish a drug abuse education program is made by individual school districts and usually only after a serious drug abuse problem has been manifested. Depending on the size of the school one or more teachers are chosen to teach drug abuse education as a separate topic. Too frequently these teachers work with unrealistic, unfactual outlines that create credibility and communication gaps in relation to their students. This situation is counter-productive.

Most drug abuse education is directed at the high school level, whereas there seems to be a more urgent and logical need for this education starting at least at the fourth grade level, and preferably as early as kindergarten.

10. Drug education must begin with the adequate preparation of teachers to understand and convey the numerous, complex facets of drug abuse. Teacher training must incorporate aspects of sociology and psychology, in addition to a working knowledge of the actual physical and psychological effects of the various drugs. A leader in this type of thorough teacher training is the Central States Institute of Addiction which offers fully accredited courses on the undergraduate and graduate levels.

11. The ambitious and innovative endeavors of the administration of New Trier High School are exemplary of the kind of enlightened community involvement which contributes greatly toward educational defenses against drug abuse. Response to the New Trier programs has been large and enthusiastic, winning the approval of educators and law enforcement authorities throughout the Winnetka vicinity. In addition to informal group discussions and radio presentations, the school now offers specific courses in drug education to freshman students, and the staff is preparing courses for adults in the community. The curricula have been designed by educators in conjunction with representatives of civic organizations, school board officials, and law enforcement officers. We believe that a substantial improvement could be made in many programs throughout the state if local school districts would express the sort of concern and dedication we observed in the Winnetka area.

12. The broadcast media have assumed diametrically opposed roles in the field of drug abuse education. On the one hand, they have contributed to the drug problem through massive advertising campaigns promoting "instant cures" for mild discomfort and emotional disorders. Moreover, some stations, until recently, failed to take steps to review the content of blatantly pro-drug popular music.

On the other hand, some members of the broadcasting community have taken commendable actions to counter the rising drug crisis by campaigns which educate children and adults on the dangers of drug abuse and make available forums for discussion of various aspects of the problem. We encourage more of the broadcasters to recognize their influential role in the environment of our society and commend those who have made significant contributions in the overall effort to educate our young people in this field.

13. The medical and paramedical professions have a profound responsibility to be highly informed about the evils of drug abuse. Of those categories physicians, psychiatrists, pharmacists, and nurses are involved on a continuous basis in the prescribing and dispensing of drugs of abuse, and in the cure and treatment of drug abusers. Moreover, they are continuously involved in counseling situations where accurate drug information is vital.

Until about 1963 medical schools devoted little attention in their curricula to the drug problem per se. Most courses of instructions were limited to the pharmacological aspects of drugs with little if any emphasis on sociological and psychological considerations or internal medicine aspects. Few schools gave any emphasis to the importance of strict self-regulation by prescribing physicians or to drug addiction treatment as a distinct health service. Some medical schools have since expanded their drug abuse education on an integrated basis but not commensurate with their increased responsibilities in view of the rapidly expanding drug abuse problem.

There is only one school of pharmacy in Illinois. It is located at the Chicago Circle Campus of the University of Illinois. Drug abuse education is interlaced in courses such as pharmacology, pharmaceuticals and chemistry. This program is commendable.

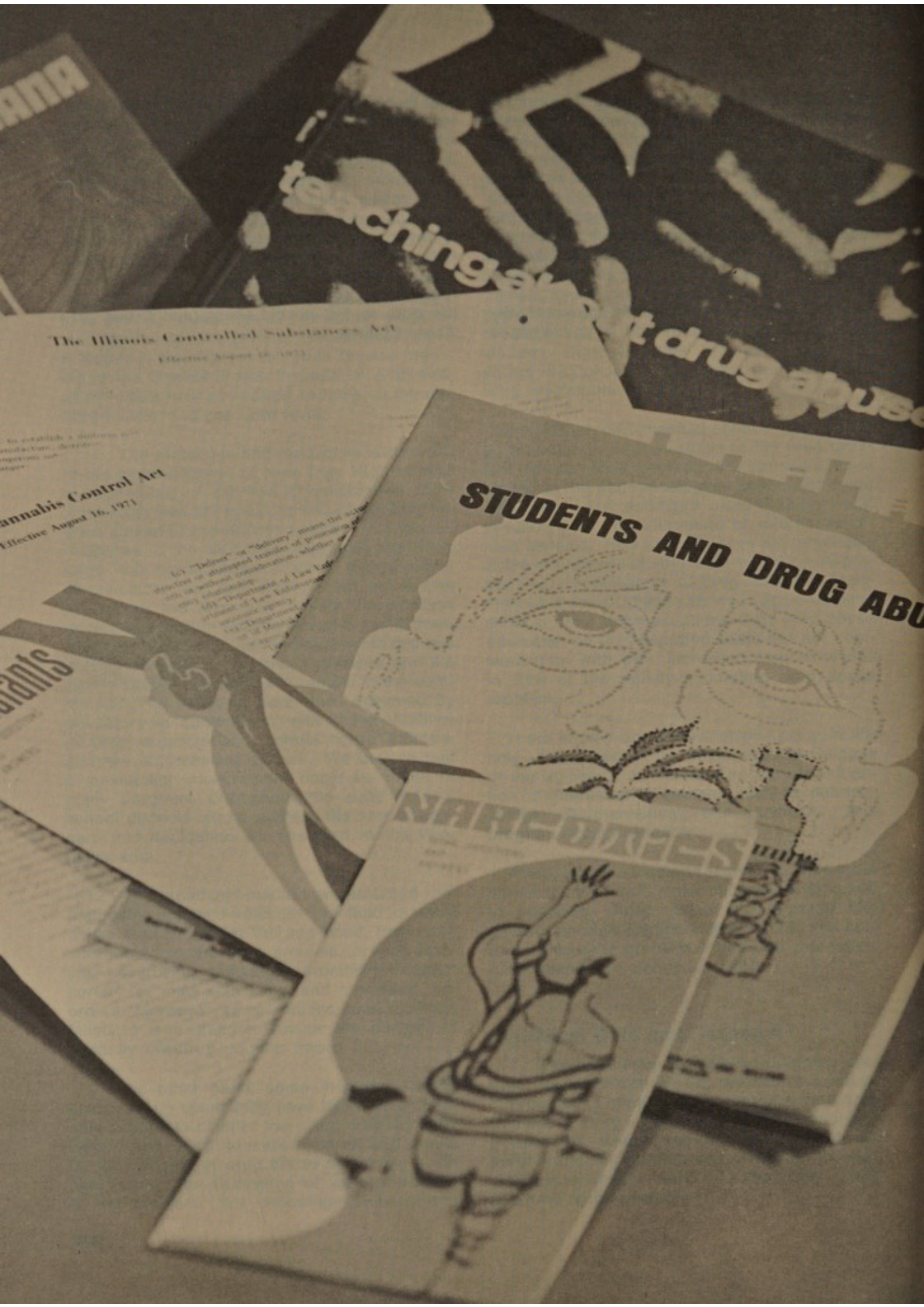
There are 73 schools of registered nursing in Illinois in senior and junior colleges, or attached to hospitals. Drug abuse is integrated into courses on physical and mental health, and current community problems. This too represents a commendable, collective effort.

Statistical Data and Research

1. It is imperative to have an on-going program to coordinate all the disciplines involved in drug abuse control, drug education, and drug treatment. Drug legislation should be continually reviewed. Annual reports should include all pertinent facts and data concerning all the disciplines to enable more effective short range and long range planning.

No one agency of Illinois state government now has the responsibility to prepare a detailed annual report involving all of the drug abuse problem disciplines. Such a factual and analytical annual report, utilizing computers, would be of much value to project the future scope of the problem and to devise new approaches to reduce the drug crisis. This should be the responsibility of the Dangerous Drugs Advisory Council.

2. The Illinois Drug Abuse Program currently treats 2,200 patients although it is estimated that there are at least 8,000 addicts in the state. However, there is now no central system for the collection of this data. Nor are there any available statistics concerning the probably larger population of persons who abuse stimulants, depressants, hallucinogens and marihuana. The comprehensive compilation of these statistics is the only logical step toward any accurate determination of the true scope of the drug abuse problem. The Illinois Drug Abuse Program should collect these statistics and transmit the data to the Illinois Dangerous Drugs Advisory Council.


The Illinois Controlled Substances Act
Cannabis Control Act
Effective August 16, 1971
STUDENTS AND DRUG ABU
NARCOTICS

Chapter 22
RECOMMENDATIONS

The following recommendations are based in large part on the foregoing conclusions. In many cases we have already taken action either in the form of specific legislation or informal recommendations to sister agencies. In others, we plan to take the action indicated in the months ahead.

Drug Regulation

1. Drug laws should reflect accepted patterns of human behavior as well as the best available research on the pharmacological effects of drugs, their degree of medical usefulness, their potential for abuse and other relevant standards of regulation. They should reflect a humane understanding of drug addiction and dependency as socio-medical problems. Judicious penalties should exist which do not unduly criminalize those who cause no social harm, yet severely punish those who cause and prosper from the misery of others. In our view, the landmark Illinois Controlled Substances Act and Cannabis Control Act embody these principles. Notwithstanding this opinion, we intend to be continually vigilant of changes in drug technology and abuse patterns in order to keep Illinois law current and relevant to this continuing crisis.

2. Marihuana is still a relative mystery in terms of its effects upon humans, especially its psychological effects after prolonged, regular use. Marihuana should not be legalized until and unless there is overwhelming scientific evidence that the drug has no serious detrimental consequences on mental ability, that it can be controlled at least as effectively as alcohol, and that its immediate effects do not add to the current problems caused by other inebriants. By all available evidence in thus far, we doubt that such a day will ever come.

3. The State of Illinois should pass a resolution calling on the federal government to halt all farm subsidy payments to tobacco producers. It is ironic that the Surgeon General has found cigarette smoking to be a serious

health hazard, and yet tobacco farmers are paid by the government in order to maintain the price level of tobacco. In effect, the federal government is acting at cross-purposes, with the tobacco farmer being the only beneficiary.

4. Businessmen and commercial organizations should formulate drug policies, even if they have not previously experienced drug problems in their companies, and ensure that responsible persons are trained to recognize the symptoms of drug abuse. Policies concerning action to be taken upon the discovery of an employee's abusing drugs should be conscientiously drawn and well publicized to avoid indecision or unfairness if the situation arises.

5. We suggest that the advertising media be more circumspect in their promotion of home-remedy pharamceuticals. In our view negligence in this regard has contributed to the general acceptance of "quick-cures" as a way of life in our society. Exaggerated claims, the encouragment of needless medication, and a general failure to publicize the dangers and liabilities inherent in the use of many home remedies have created the impression that all drugs are safe and that there need be no concern for possible deliterious effects if the medication is allowed to be sold without a prescription. We believe that the advertising industry's self-discipline in this case is more desirable than governmental intervention over the content of commercial messages.

6. Some form of legal controls might be placed on the sale of technically "legal" drug materials which are advertised as having the same or similar effects as certain illegal drugs. For example, one seller in California advertises "Legal Hash" in a local underground newspaper, the term "Hash" obviously referring to hashish, a concentrated form of marihuana. The "Legal Hash" is mailed in unlabeled packages, and police laboratories have found the substance to be catnip. It can be assumed that buyers of "Legal Hash" will ingest this substance, possibly to their physical or psychological detriment.

7. Government censorship of drug-oriented rock music cannot be countenanced or justified. However, we would suggest that manufacturers of phonograph records and the mass communication media adopt self-disciplinary policies to discourage the future promotion of such material. Further, we would recommend their encouragement of lyrics which would discourage drug abuse and popularize healthy and constructive alternatives, while retaining the same, appealing rhythms. Some phonograph record manufacturers and radio stations have already shown the way in that direction. We applaud their foresight and social concern.

Law Enforcement

1. Law enforcement efforts should be directed toward the drugs which pose the most serious threat to the general welfare. As reflected in the new drug laws, marihuana should be of secondary interest as compared to heroin, LSD, or other Schedule I and II drugs.

2. Police departments in the larger metropolitan cities and counties, as well as the Illinois Department of Law Enforcement, should re-examine their drug law enforcement programs to ensure that appropriate and prompt attention is given to the detection and apprehension of major intrastate and local traffickers, and the collection of intelligence data for the development of conspiracy prosecutions against these criminals. Separate sections should be established within the framework of the major existing agencies to concentrate on the development of qualitative investigations aimed solely at large sources of supply.

3. We suggest that a significant impact can be made against the illegal drug distribution complex only through the cooperative efforts of federal, state and local law enforcement units. Each level of law enforcement enjoys particular advantages which can be employed in a maximum effort against drug criminals. The development of Metropolitan Enforcement Groups (MEG) is a forward step in creating this greatly needed coordination among local police agencies.

4. The activities of the A.I.D.S. groups mentioned previously can be of substantial assistance to law enforcement efforts against drug abuse. We congratulate these and other citizen organizations designed to complement law enforcement, and we urge their expansion.

5. The state should provide for monetary rewards for confiscations of significant amounts of illicit drugs, to be paid upon the arrest and conviction of the person or persons possessing or selling such drugs. The Commission fur-

ther recommends that the Illinois Department of Law Enforcement be authorized to institute an incentive award program of monetary rewards and/or certificates of special commendation to those officers responsible for outstanding drug enforcement accomplishments, in the same fashion that is employed by the United States Bureau of Narcotics and Dangerous Drugs.

6. State law enforcement agencies should be provided with enough cash to make "drug buys" to facilitate arrest and conviction of large sellers of illicit drugs.

7. The search warrant procedure in the investigation of known circumstances of pushing of drugs should be simplified. A search warrant could be issued by telephone or radio systems, be recorded on tape and, within a well-defined period of time, be reduced to writing.

8. A study should be undertaken by a competent body to examine the incidence of bail-jumping in relation to drug-related crimes. Since the damage wreaked by traffickers in illegal drugs is exceptionally great in proportion to the numbers of persons so involved, it may be justified to provide that bail be denied for certain classes of serious offenses.

9. A study should be undertaken by a competent body to evaluate the judicial machinery in relation to drug prosecutions. This study should indicate means by which the criminal process may be expedited in order to reduce or eliminate the unnecessary delays now resulting from the very large case load in narcotics court. The study should examine ways to expedite the chemical testing process in police laboratories for the identification of evidence, and explore the need for a third narcotics court and additional prosecutors in Cook County.

10. It should be mandatory that all persons convicted of drug-related crimes must submit to periodic chemical detection tests as a condition of parole or probation. The detection of drug use should be grounds for immediate initiation of commitment proceedings.

11. Judges should impose substantial pentitentiary sentences on convicted, professional drug peddlers and discontinue the practice of probation and other leniency for major, recidivist violators.

Treatment

1. The State should appropriate funds for the Illinois Drug Abuse Program to allow that agency to expand its facilities, hire and train additional staff personnel, engage in comprehensive research and evaluation studies, and explore new areas where state efforts may help to stem the rising tide of drug abuse. The state's goal should be sufficient capability to offer treatment and rehabilitation services to all drug dependent persons on the very day they seek help.

2. The state should support the development of drug treatment and rehabilitation facilities within the operations of the Department of Corrections.

3. The state should undertake to evaluate each of the treatment modalities to determine their relative effectiveness and to determine the characteristics of drug abusers who respond best to each modality. This should be accomplished through an impartial, professional evaluation team, and might utilize such devices as the Standard Personality Profile tests to arrive at its conclusions. Results of this evaluation will aid the state in determining which modalities are most deserving of funds, and will aid in the appropriate disposition of addicts who seek help.

4. The state should develop a training program to provide qualified staff personnel for the Illinois Drug Abuse Program. This might be accomplished by providing scholarships to medical technology or nursing students who agree to take specialized drug abuse courses and then agree to work for the state a predetermined length of time.

5. Therapeutic communities must stress the eventual re-entry into society of their "residents". They should provide adequate emotional and vocational guidance so that the former drug-abuser is able to return to society as a productive member. They should not tolerate the perpetual residency of any drug-abuser except as a last resort.

6. Private physicians should not be permitted to operate methadone maintenance programs unless they can demonstrate their adherence to strict security controls, their ability to provide colateral services, and their ability to perform adequate follow-up surveillance on their patients.

7. Illinois should resist all efforts to institute the "British System" of dispensing drugs to addicts in order to destroy the illegal drug market. There is convincing evidence that such a policy would only serve to increase the addict population and multiply our now alarming drug problem.

8. All facilities which hold themselves out to offer treatment and rehabilitation for drug abuse should be licensed by the state. Many individuals and organizations advertise such services and charge substantial fees, and yet there is no state supervision over their methods or facilities. Of course, the state at this time cannot advocate any particular treatment modality as the "best"; the treatment sciences are still in a state of development. However, the state can ensure that the persons who offer treatment services are qualified to engage in whatever practice their approach contemplates, and screen out unscrupulous or incompetent practitioners before they perpetrate frauds upon the public.

9. Legislation should be enacted to provide for the civil commitment of drug dependent persons, offering to them meaningful treatment and rehabilitation services. A study should be made of similar statutes in force in New York and California to endure that any proposed Illinois statute is able to meet constitutional challenges on its terms.

Education

1. The existing law should be strictly enforced requiring all applicants for teaching certificates to have taken drug abuse education courses prior to certification. Rather than assigning one or more teachers to give separate lectures on drug abuse education, all teachers should show the relationship between drug abuse and the specific curriculum courses. With the exception of subjects such as mathematics, this relationship can be demonstrated within the framework of nearly all regular subjects, such as government, civics, mental and physical health, geography, history, literature.

2. We would suggest that all drug abuse education, at all levels, be restricted to factual presentations and be devoid of exaggerations, distortions, or dishonesty. To be effective, teachers should emphasize frankness and relevance, and devote particular attention to counteracting peer group pressures and the avoidance of teaching methods which arouse a morbid curiosity to experiment with drugs.

3. Every school of education in Illinois universities and colleges should require a separate semester or quarter course in drug abuse education for each degree candidate.

4. Each of the six medical schools in Illinois should discard its current practice of teaching drug abuse as a corollary aspect of certain curriculum courses. Instead, these schools should establish a separate multidisciplinary course on the nature and characteristics of drug abuse, designed by the pharmacology, social sciences, psychiatry, and internal medicine departments. Since drug abuse is acknowledged as a medical problem, a total, in-depth knowledge can only be acquired through such comprehensive training.

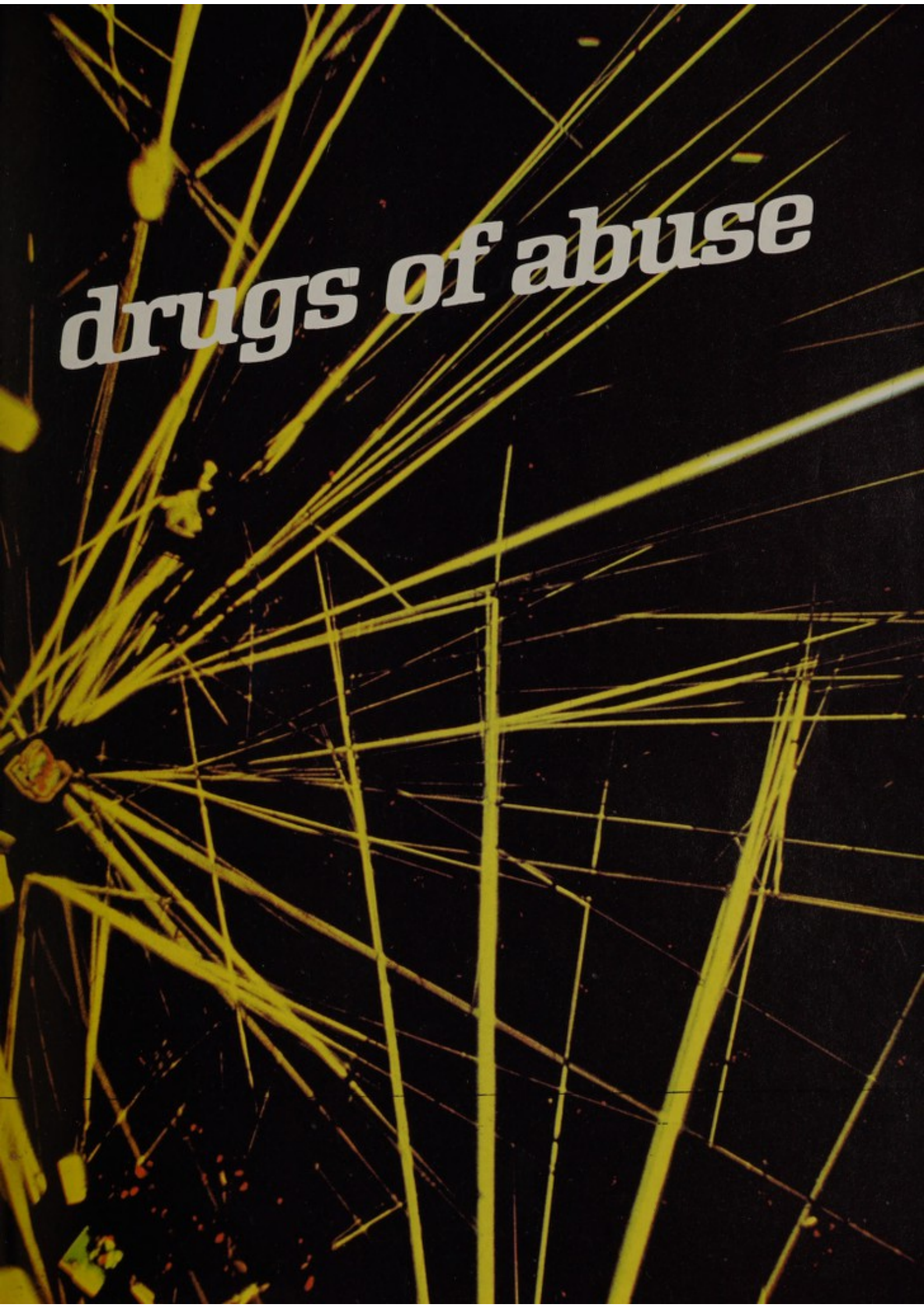
5. The law enforcement community should take a more active role in the drug education effort. Police officers, enjoying tremendous respect among the very young, can utilize their status to convey anti-drug messages in the classroom. The presentation should be marked by ingenuity, honesty and frankness.

6. State efforts at drug education cannot be limited to the school children. Parents and adults must also be educated so that they may understand the complex motives behind drug abuse among the young. Further, they must be able to recognize the symptoms of drug abuse so that they may help their children before the problem defies solution.

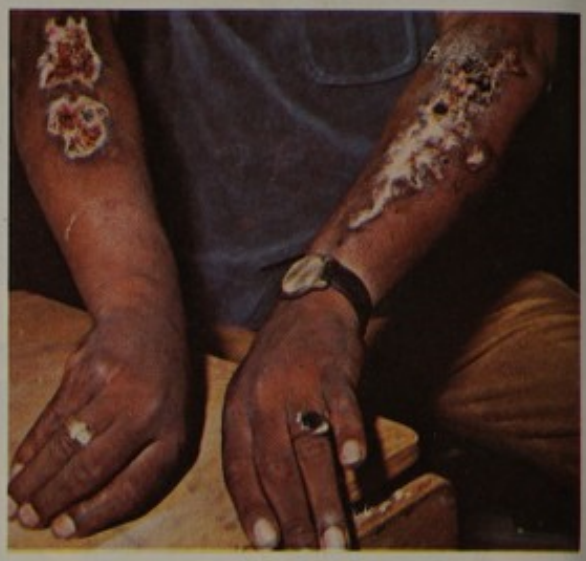
Statistical Data and Research

1. The Illinois Dangerous Drugs Advisory Council should act as a central collection agency of drug abuse statistics and relevant scientific data. These data should be summarized and included in the Council's annual report to the General Assembly and the Governor. It would also be desirable to include the general public in this distribution. The Council should also, in conjunction with the Superintendent of Public Instruction, devise separate, detailed curriculum outlines for drug abuse education in elementary, secondary, and university level schools in the state. All schools, whether or not they are located in geographical areas now experiencing serious drug abuse problems, should be required to follow these curriculum outlines for prevention purposes. The Council should also collect statistics concerning drug prosecutions and other court dispositions, with an appropriate analysis.

2. We recommend the adoption of a Uniform Drug Arrest Form (UDAF) to be used by all Illinois law enforcement agencies. This form should include all data necessary to accurately assess the drug problem in the state and to identify its characteristics. The information gathered through the UDAF should be collected at a central point and computerized to provide immediate information to law enforcement, research, and treatment agencies in the state, including the Illinois Dangerous Drugs Advisory Council.


drugs of abuse

Identification of Narcotics Morphine has generally been diverted from legitimate stocks in white powder, tablet or liquid form, and infrequently in cubes. Brick morphine base seldom reaches this country. Heroin comes in fine powder ranging from off-white to dark brown, and occasionally purple. It is packaged and sold in capsules or wax paper and foil "decks" depending on the quantity. The loose drug or pre-packaged heroin is often carried in balloons or other plastic containers to facilitate concealment. Codeine has been diverted and appears in white powder, hypodermic tablet or solution form.



Man has used drugs since the beginning of time. He also abused these powerful drugs to escape from life and betrayed their medicinal value. Today, drug abuse remains a problem to society. To solve the problem, man must educate himself to the potent nature of the drugs of abuse.

The opium poppy—a beguilingly beautiful flower—grows in sections of Mexico, the Near and Far East. Cultivators process poppy juices into crude opium to prepare smoking opium or, most often, morphine base, identified with "999" or other trademarks. Clandestine laboratory operators then process the base drug to make morphine, codeine, or heroin for the United States market.

Abusers usually inject narcotics. Hence, the addict's equipment, the "works," is a strong indication of narcotic abuse. Because they use and share contaminated needles, addicts often contract hepatitis, tetanus, tissue infections and abscesses of the skin and various organs.

Heroin is the most popular narcotic drug of abuse, because of its intense euphoria and long lasting effect. It is synthesized from morphine and nearly 10 times as potent, but has no legitimate use in the U.S. Traffickers "cut" or dilute pure heroin so it normally ranges between 3% and 10% pure when sold to the addict.

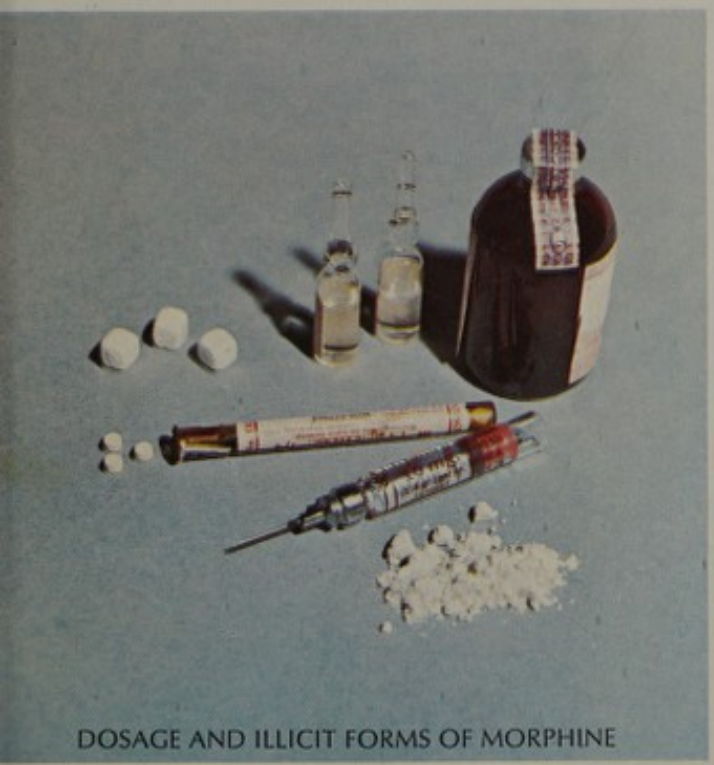
Doctors prescribe morphine to relieve pain, but addicts rank it second to heroin. They may abuse morphine when heroin is scarce.

Codeine is most frequently abused when in cough syrups, but occasionally the pure drug is abused. Its effects are milder when compared to heroin and morphine.

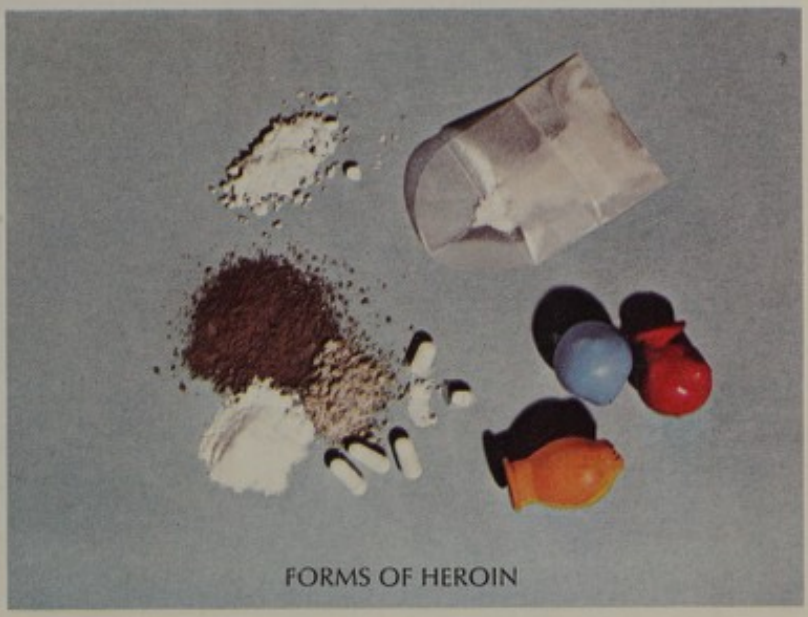
Narcotics

MORPHINE BASE

OPIUM POPPY & DERIVATIVES
CRUDE & SMOKING OPIUM, CODEINE, HEROIN, MORPHINE

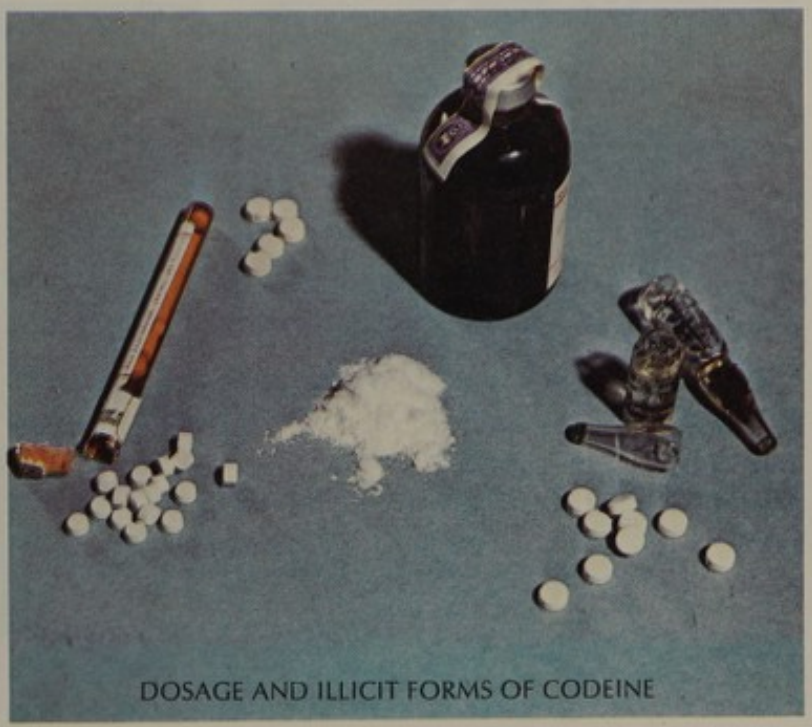


DOSAGE AND ILLICIT FORMS OF MORPHINE



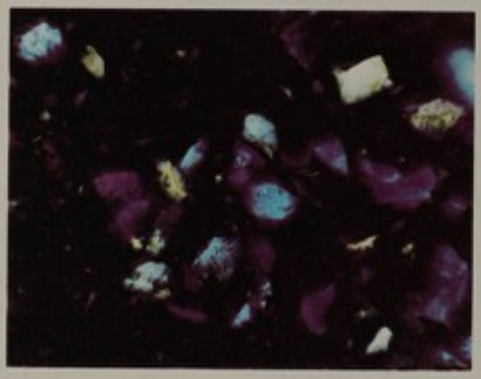
FORMS OF HEROIN

ADDICT'S EQUIPMENT



DOSAGE AND ILLICIT FORMS OF CODEINE

Identification of Narcotics Cocaine is a crystalline structure. Resembling epsom salts or snowflakes (nickname "snow") it reflects light. Hydromorphone, a semi-synthetic and opium derivative, and true synthetic narcotics, methadone and meperidine, are usually diverted from legitimate channels. They are found in white tablet or liquid form, and Dilaudid also appears in larger compounding tablets. Exempt narcotic cough preparations containing codeine are of syrupy consistency ranging from clear to dark brown. Exempt paregoric preparations containing camphorated tincture of opium are yellowish brown liquids.

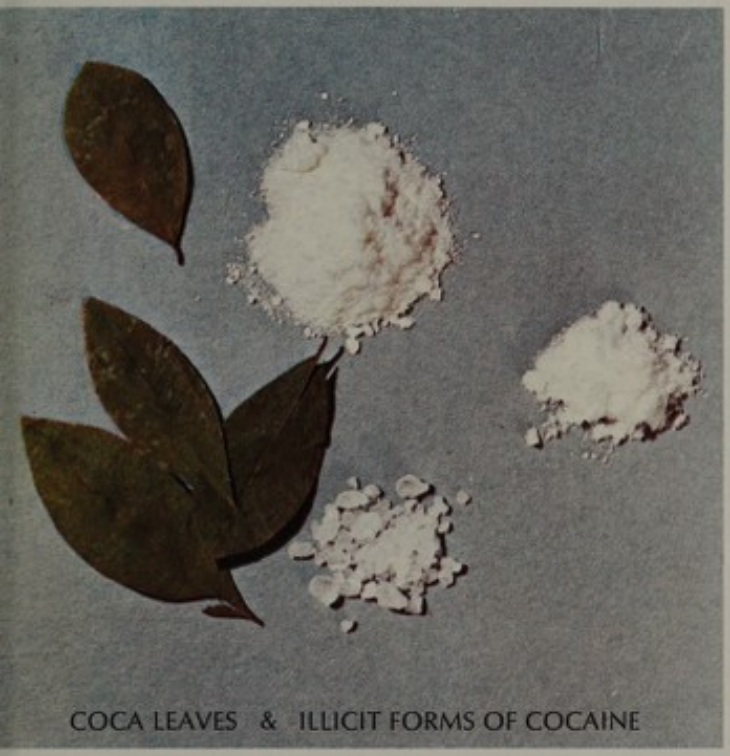


The coca bush grows in the Andes Mountains of South America. Farmers process its leaves into coca paste, then cocaine. Federal law classifies it as a narcotic, but pharmacologically it stimulates the central nervous system. People in some parts of the world chew coca leaves, but abusers in the U.S. generally inhale ("snort") or inject it into the body after mixing the crystalline powder with heroin.

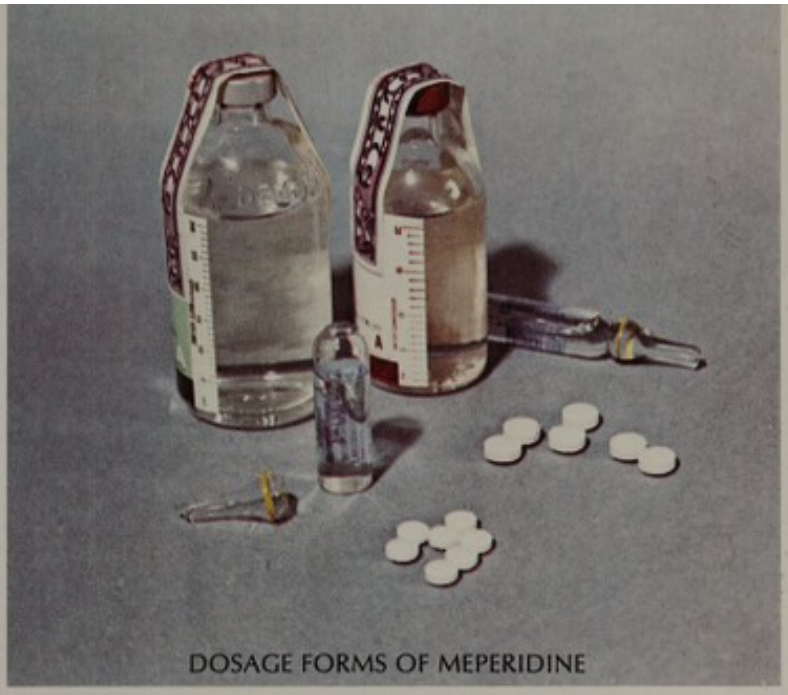
Hydromophone, a semi-synthetic drug and opium derivative, is made from an opium extract or through a chemical process or a combination of both procedures. Meperidine was the first synthetic narcotic created. Methadone, another synthetic narcotic, is currently used in research as clinical treatment for heroin addiction. These drugs and all 81 semi-synthetic and true synthetic drugs have properties similar to opium derivatives. Each is considered a dangerous narcotic.

Exempt narcotics contain small amounts of narcotic drugs in combination with other drugs. They include codeine cough syrups and preparations of camphorated tincture of opium such as paregoric. When used as directed, they are reasonably safe and free of addiction potential. But young people frequently abuse exempt narcotics and addicts may substitute them when more potent drugs are not available.

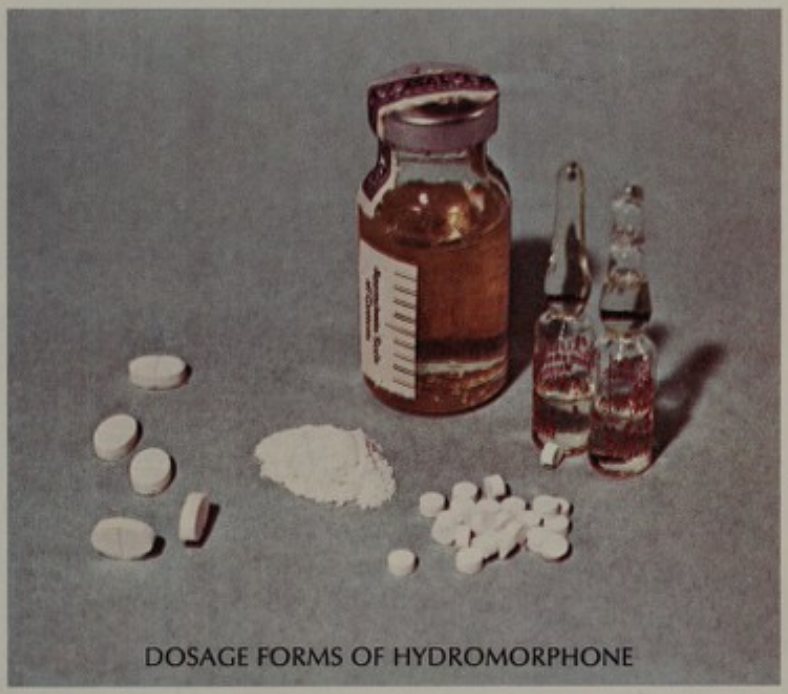
Narcotics



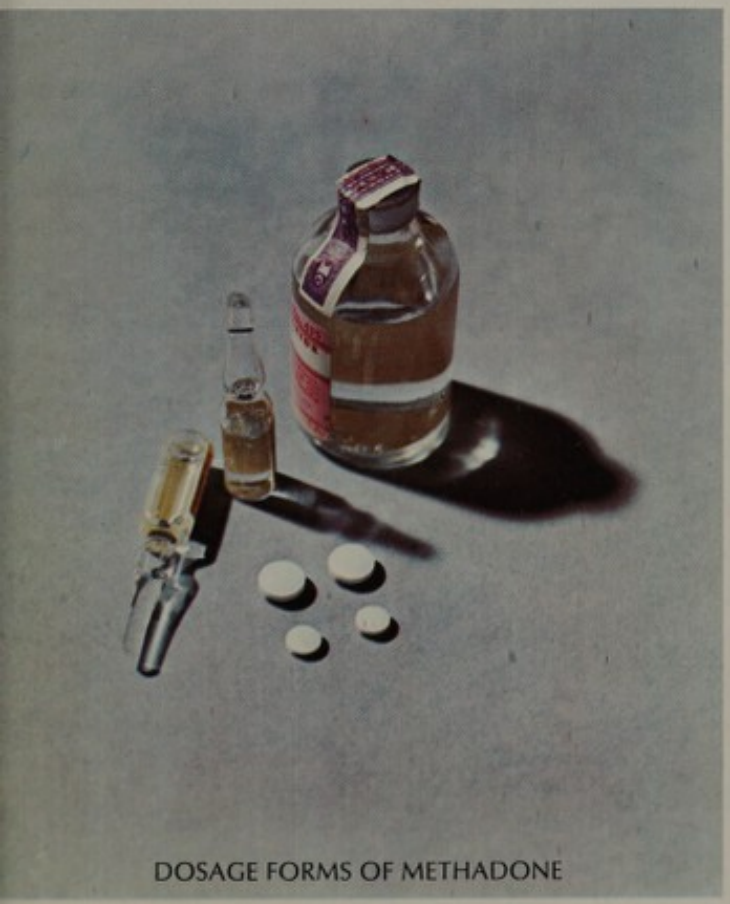
COCA LEAVES & ILLICIT FORMS OF COCAINE



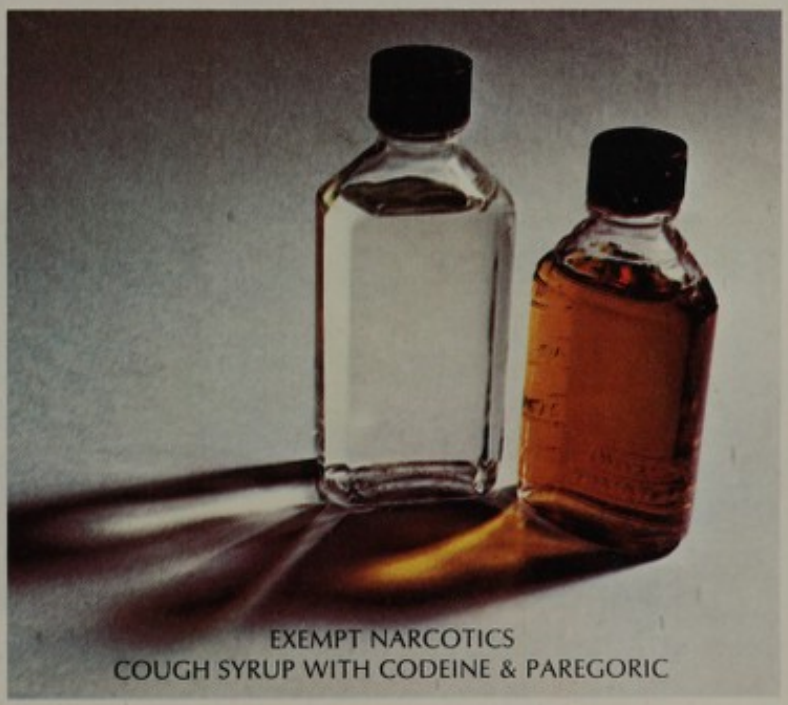
DOSAGE FORMS OF MEPERIDINE



DOSAGE FORMS OF HYDROMORPHONE

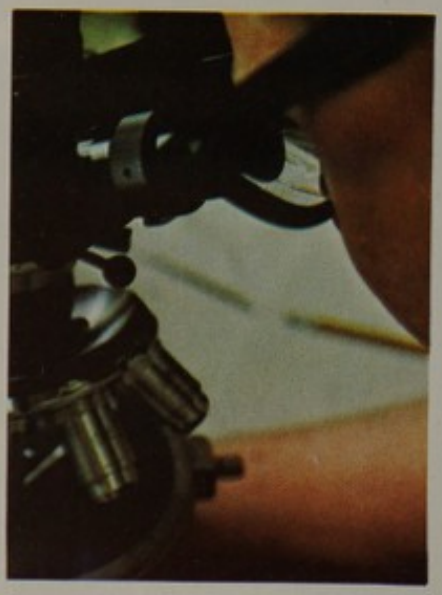


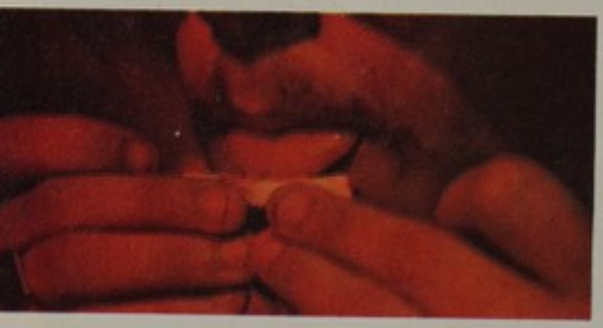
DOSAGE FORMS OF METHADONE



EXEMPT NARCOTICS
COUGH SYRUP WITH CODEINE & PAREGORIC

Identification of Marihuana Marihuana leaves have an odd number (5, 7, 9, etc.) of serrated leaflets. Hashish is a light green-brown, dark brown or black oblong, flat cake from 1/4 to 3/4 inches thick. These loaves or "soles" are broken into small irregular "cubes" or "chunks" and sold by the gram. Manicured marihuana is a finely ground green substance that looks much like coarsely ground oregano or, when less finely processed, thyme. It is generally packaged in match boxes, plastic bottles, tins and other small containers for retail sale. In brick form, large pieces of marihuana twigs, stalks, leaves and seeds have been compressed into blocks, called "kilobricks" measuring about 5 x 2 1/2 x 12 inches. Sometimes a finely processed veneer covers the coarse brick core. Cigarettes, generally shorter and smaller in diameter than the commercial type, contain manicured marihuana. Both ends are "crimped" or "twisted." Occasionally tobacco in regular filter-tip cigarettes has been removed and marihuana inserted, but unless the end is "crimped" the fine marihuana will fall out.





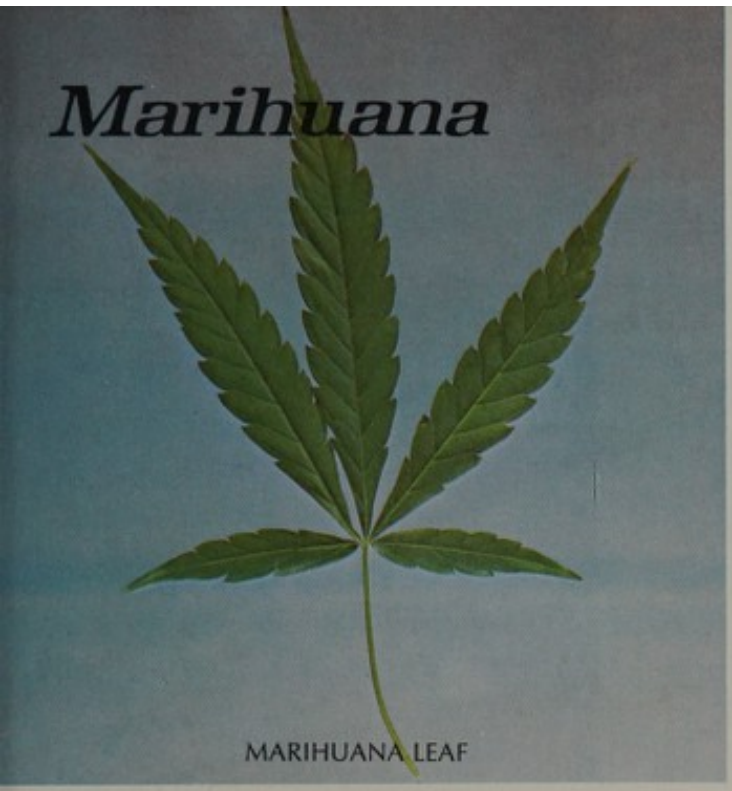
Marihuana was discovered 5,000 years ago. The plant, Cannabis sativa L., grows in mild climates throughout the world especially Mexico, Africa, India and the Middle East. The strength of the drug differs from place to place, depending on where and how it is grown, how it is prepared and how it is stored.

Traffickers frequently include all parts of the plant including seeds and stalks—sometimes grass, alfalfa, other drugs or diluents—in marihuana preparations. Sophisticated abusers insist on and pay high premiums for the more potent preparations of cannabis resin or the female flowering top of the plant. In 1966, a scientist synthesized the active ingredient of marihuana, tetrahydrocannabinol.

Abusers usually smoke marihuana in cigarettes, hookahs or pipes with small bowls. Some smokers make removable tin foil bowls to hold the marihuana. They also use wire "roach holders" or paper clips to smoke the whole cigarette.

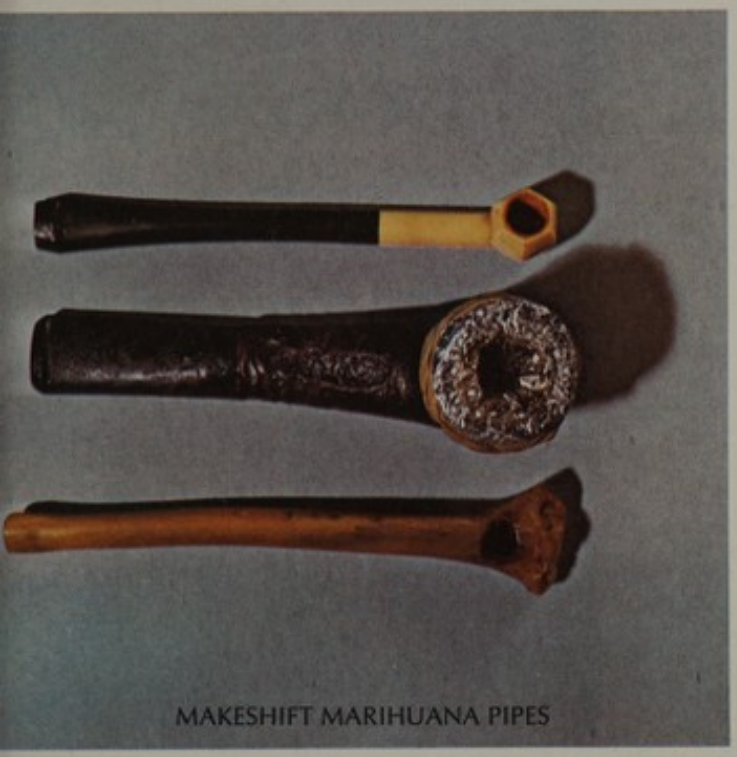
Marihuana use in other countries and current scientific information indicate it is a dangerous drug. At the same time researchers in this country are carefully exploring the drug's short and long term effects.

Marihuana



MARIHUANA LEAF

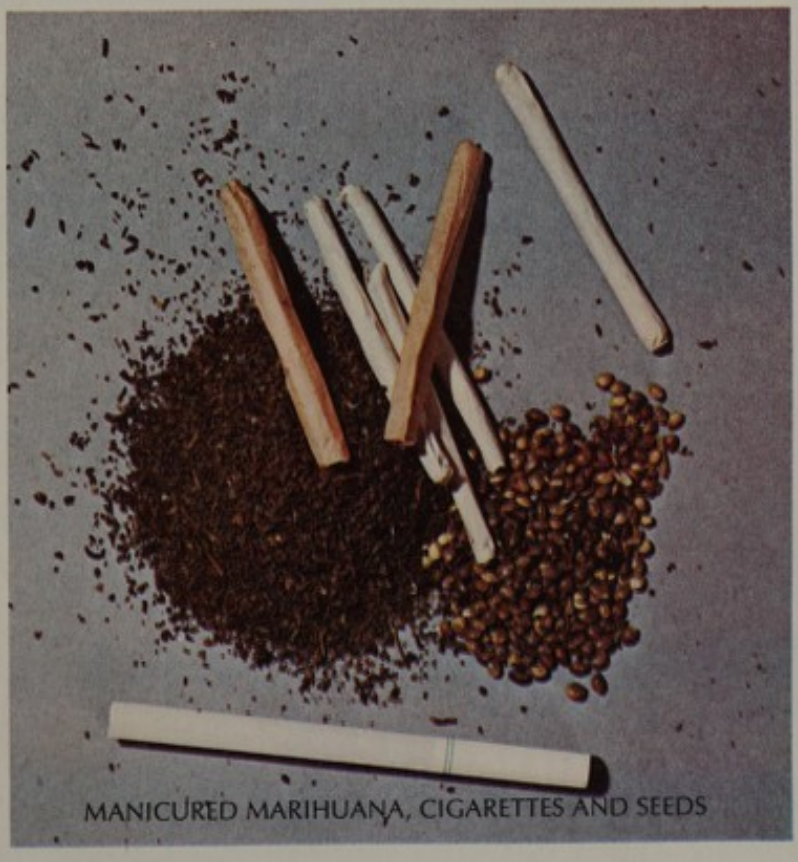
RETAIL FORMS OF MARIHUANA



MAKESHIFT MARIHUANA PIPES

KILO BRICKS OF MARIHUANA

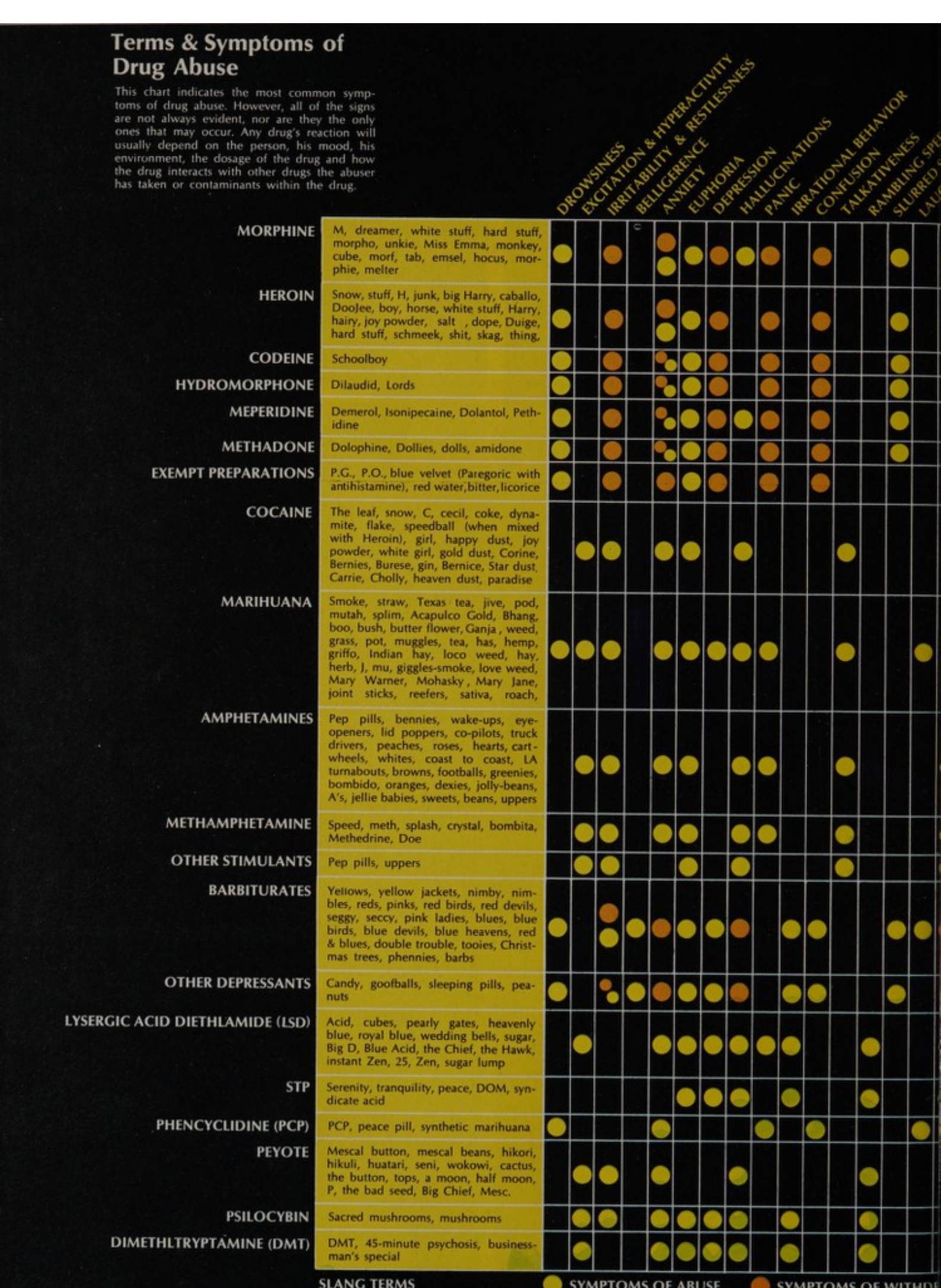
HASHISH

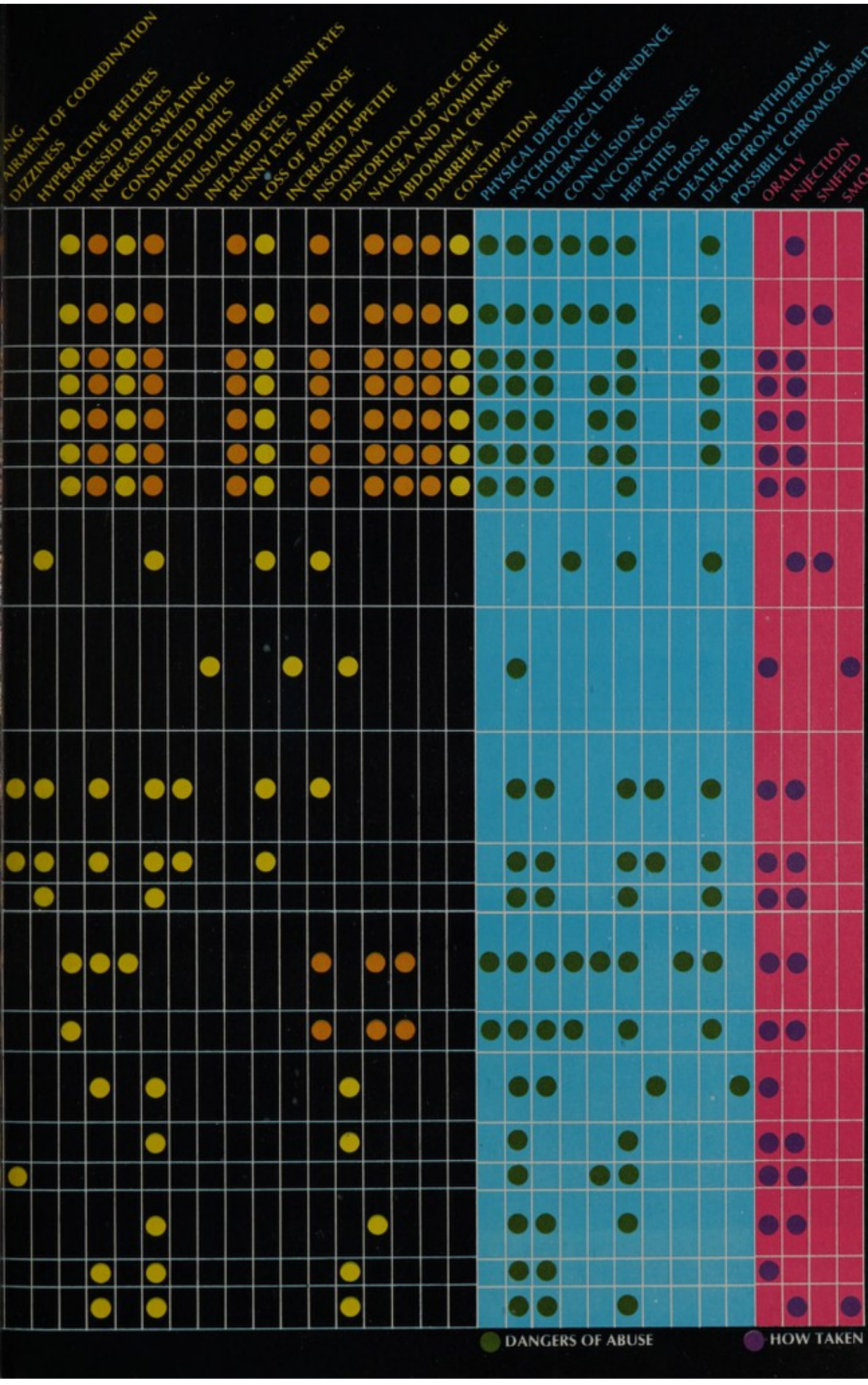


MANICURED MARIHUANA, CIGARETTES AND SEEDS

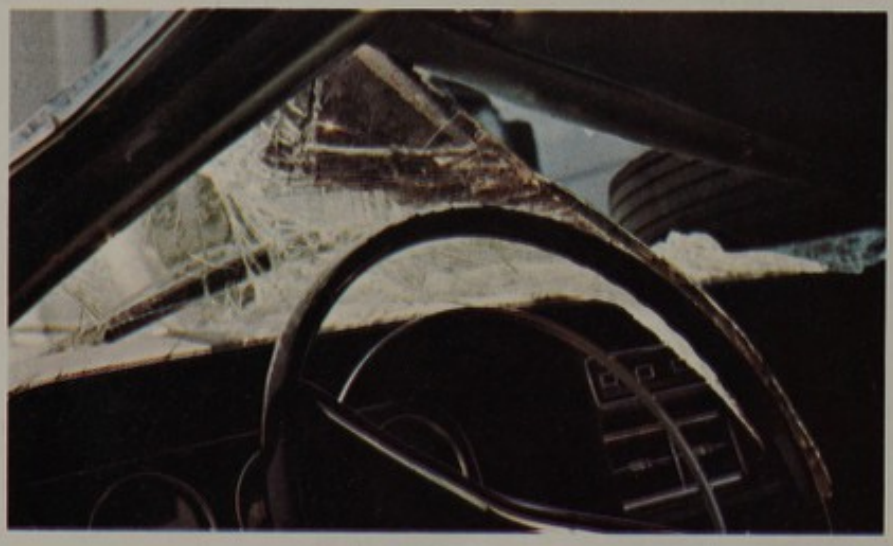
Terms & Symptoms of Drug Abuse

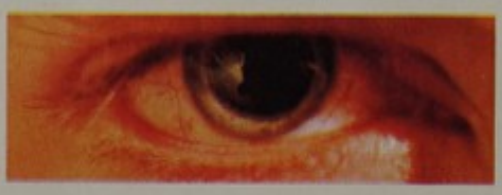
This chart indicates the most common symptoms of drug abuse. However, all of the signs are not always evident, nor are they the only ones that may occur. Any drug's reaction will usually depend on the person, his mood, his environment, the dosage of the drug and how the drug interacts with other drugs the abuser has taken or contaminants within the drug.




NG
AIRMENT OF COORDINATION
DIZZINESS
HYPERACTIVE REFLEXES
DEPRESSED REFLEXES
INCREASED SWEATING
CONSTRICTED PUPILS
DILATED PUPILS
UNUSUALLY BRIGHT SHINY EYES
INFLAMED EYES
RUNNY EYES AND NOSE
LOSS OF APPETITE
INCREASED APPETITE
INSOMNIA
DISTORTION OF SPACE OR TIME
NAUSEA AND VOMITING
ABDOMINAL CRAMPS
DIARRHEA
CONSTIPATION
PHYSICAL DEPENDENCE
PSYCHOLOGICAL DEPENDENCE
TOLERANCE
CONVULSIONS
UNCONSCIOUSNESS
HEPATITIS
PSYCHOSIS
DEATH FROM WITHDRAWAL
DEATH FROM OVERDOSE
POSSIBLE CHROMOSOME DAMAGE
ORALLY
INJECTION
SNIFFED
SMOKED
DANGERS OF ABUSE
HOW TAKEN

Identification of Stimulants Illicit amphetamines are most frequently in tablet and capsule form, occasionally as powders and rarely in liquid form. While more popular brand name stimulants bear trademarks or other identifying symbols, tablets vary widely, in color, size and shape. They may be unscored, single scored or double scored; any color, shape (round, heart, square, triangular, oval, etc.) and size (varying in thickness; curved or flat; with beveled or unbeveled edges). Some are candy coated while others are not. Amphetamine capsules may be solid color, but are most often clear, filled with powder or multicolored time- disintegration beads. Methamphetamine also appears in powder, tablets or solution form for injection.



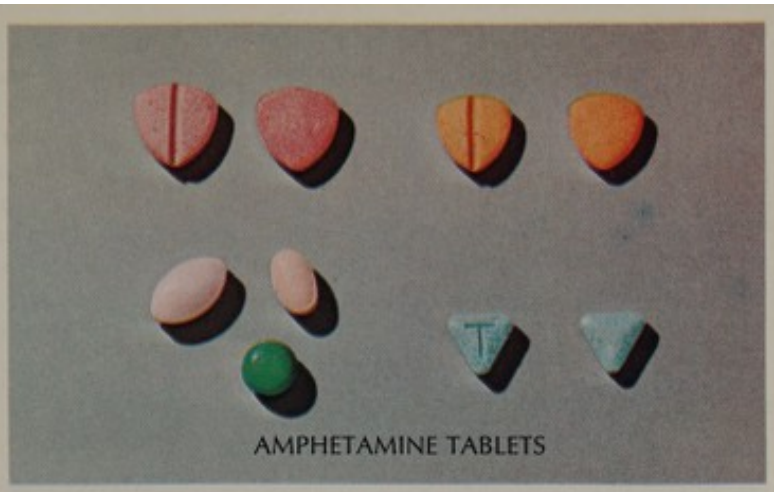


Stimulants directly affect the central nervous system. Their ability to produce increased activity, alertness and excitation has prompted people to call them "pep pills." Amphetamines are the most widely known and frequently abused stimulants. Doctors use them to treat obesity and mild depression. Abusers tend to be accident prone. They are especially dangerous on the highway, because the drugs' effects mask fatigue and abusers exceed their physical endurance without realizing it until it's too late. Criminals may also use amphetamines to bolster their courage before committing a crime.

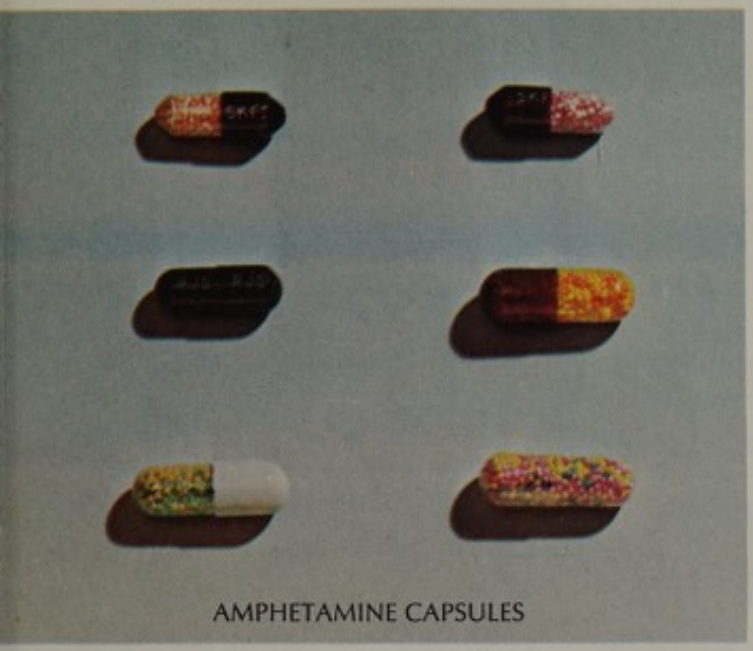
The shapes, colors, effects and uses of amphetamines often spark slang names. For instance rose colored, heart shaped amphetamines are known as "peaches," "roses," or "hearts," while long acting capsules are often called "coast-to-coast," "L.A. Turnabouts," or "co-pilots."

Methamphetamine is a powerful, but widely abused stimulant. Chemically related to the amphetamines, it has greater psychological effect. Abusers shoot "meth," or "speed," intravenously and use equipment similar to the narcotic abuser's. The drug culture has coined a slogan to warn others that "speed kills" and indeed an overdose of the drug may cause death.

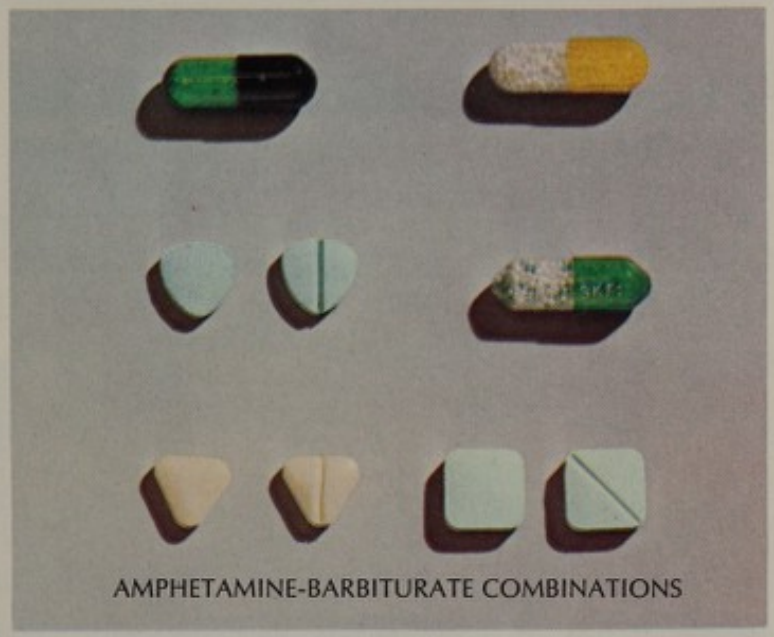
Stimulants



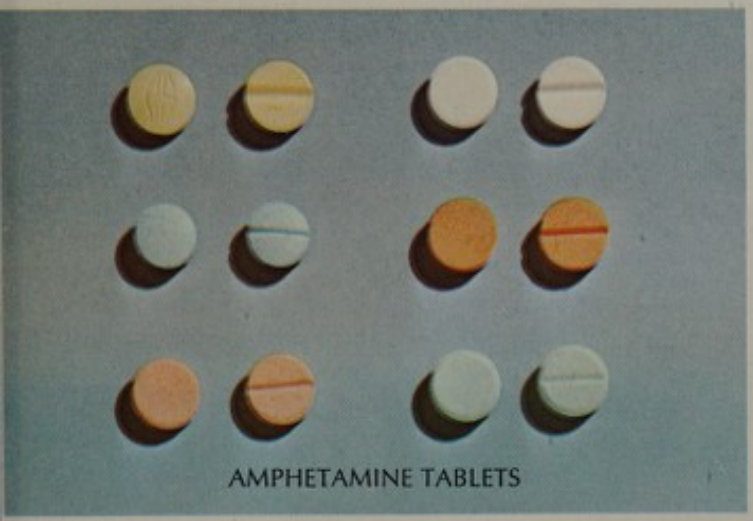
AMPHETAMINE TABLETS



AMPHETAMINE CAPSULES

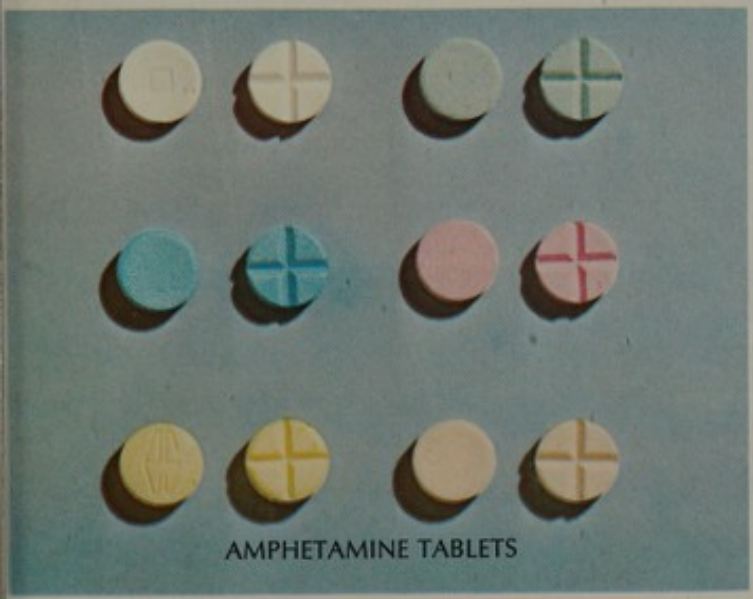


AMPHETAMINE-BARBITURATE COMBINATIONS



AMPHETAMINE TABLETS

DOSAGE FORMS OF METHAMPHETAMINE



AMPHETAMINE TABLETS

PHENMETRAZINE TABLETS

Identification of Depressants Depressants in illicit traffic have often been diverted from legitimate channels. Popular brand name depressants bear trademarks or other identifying symbols. They are found in tablet and capsule form with capsules predominant. Tablets are usually round with no scoring or a single score. They may be sugar coated or uncoated in a variety of shapes with or without markings. Capsules vary in color, but are frequently red ("redbirds"), yellow ("yellow jackets"), blue ("blue heavens") or red and blue ("Christmas trees"). Barbiturate capsules range widely in size and are usually filled with powder and occasionally time disintegration beads. Depressants also appear as solutions for injection and as white powder.

This group of drugs depresses the central nervous system and relieves anxiety. They are valuable when used properly but extremely dangerous when abused.

Barbiturates are depressants. The first barbituric acid derivative was introduced to medicine shortly after the turn of the century. Since then, hundreds of barbiturates have been synthesized. They are prescribed as sedatives and to induce sleep, or in smaller doses, to provide a calming effect. Legally, people can buy and use these drugs only with a doctor's prescription, but they are extensively abused.

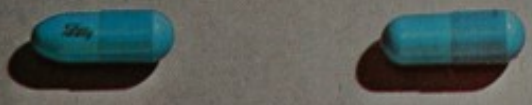
Barbiturate abusers often are involved in traffic accidents because their reactions tend to be sluggish. Accidental deaths from overdoses of barbiturates are common because abusers become confused as a result of the effects of the drug and forget how many they have already taken. The combination of alcohol and barbiturates can be lethal.

These drugs are addicting. Signs of physical dependence appear with doses well above therapeutic level. Withdrawal from barbiturates is especially dangerous and is characterized by accompanying convulsions and delerium. Depressants — they're real downers!

Depressants

PENTOBARBITAL CAPSULES

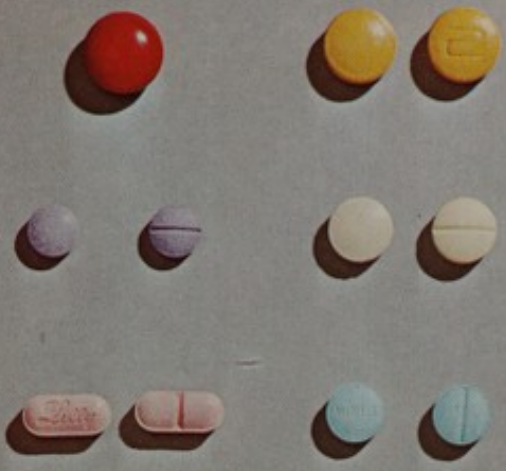
SECOBARBITAL CAPSULES



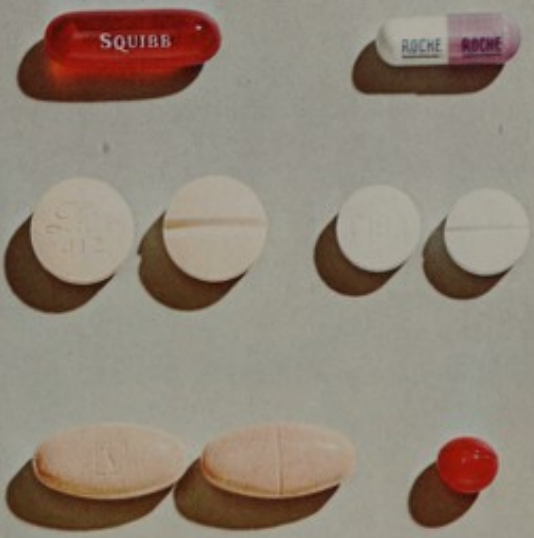
AMOBARBITAL CAPSULES

AMOBARBITAL WITH SECOBARBITAL

PHENOBARBITAL TABLETS



MISCELLANEOUS BARBITURATE TABLETS



OTHER DEPRESSANT DRUGS

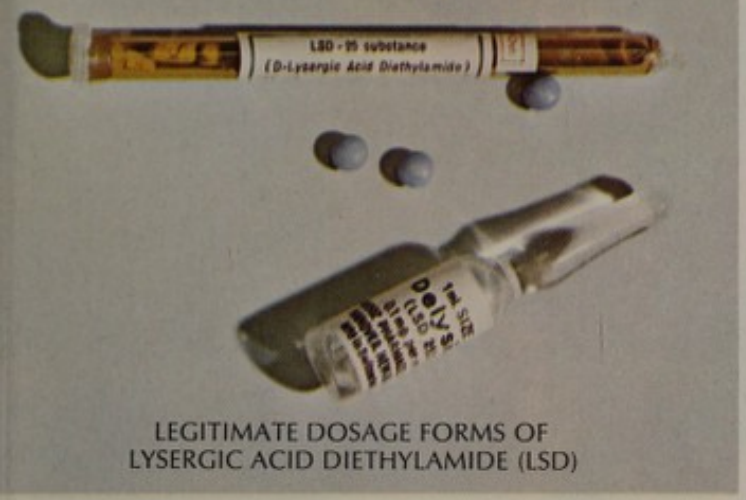
Identification of Hallucinogenic Drugs Hallucinogenic drugs originate in clandestine labs with no standard dosage forms or markings. The home-made capsules and tablets come in all shapes, sizes and colors, or nondescript powders and liquids. They can easily be disguished as common substances. For example, the colorless, odorless, and tasteless drug LSD has been found on sugar cubes, chewing gum, candy, crackers, blotter paper, postage stamps, handkerchiefs, aspirins, vitamins, beads and other personal jewelry. LSD will fluoresce under ultraviolet light. The drug STP (DOM) appears in powder, tablet, and capsule form, varying in size and shape. Peyote cactus is found as dried "buttons" or as ground brown powder in capsules. One of its active ingredients, mescaline, frequently appears in illicit traffic as white powder in capsules. The Psilocybe mushroom and its derivative have appeared in this country's illicit traffic. DMT, a crystalline powder, is often mixed with parsley, oregano or marihuana, but also appears in liquid form. PCP appears in tablet, capsule and powder form from clandestine labs and often sold under the guise of synthetic marihuana.

Hallucinogens encompass a wide variety of drugs capable of producing illusions or hallucinations. The experience may be exhilirating or terrifying. There is no way to predict which road a "trip" will take.

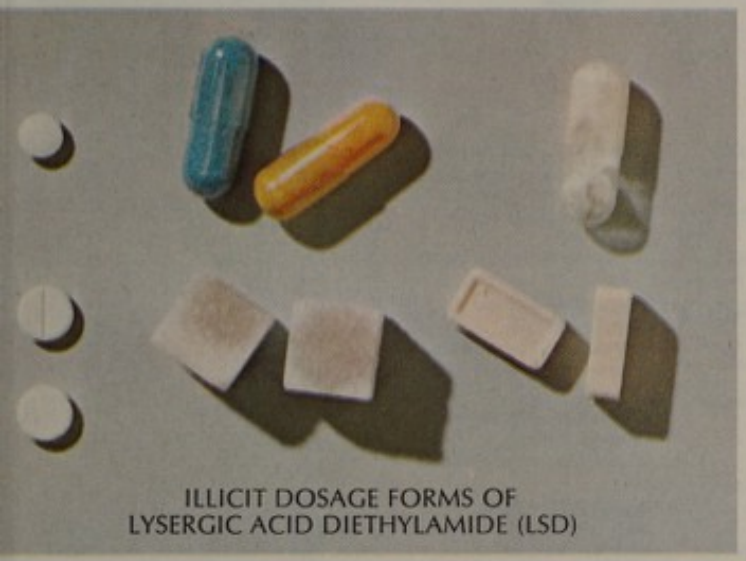
Some users say they see sounds, taste colors and hear motion. Others panic, have psychotic or antisocial reactions with impulses toward violence and self-destruction. Under the influence of hallucinogens, the abuser's ability to separate fact from fantasy diminishes. He sees himself and his environment in a distorted frame of reference. **Manufacture or use** of nearly all hallucinogens is prohibited in the U.S., except for approved research. PCP is used as a veterinary anesthetic. However, these drugs are being tested extensively in the laboratory to discover their potential values as well as dangers. Current research includes the study into LSD's possible effects on unborn children.

Many of these mind-affecting drugs come from plants. LSD can be produced from the ergot fungus on rye. Peyote and its more active ingredient, mescaline, come from a cactus native to the southwest and Mexico. DMT can be made chemically or from extracts of a plant grown in the West Indies and South America. Psilocybe is a variety of Mexican mushroom. STP and PCP are made chemically.

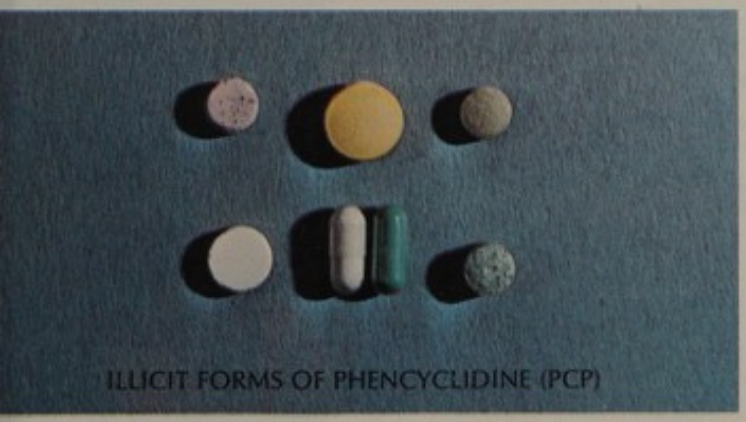
Hallucinogens



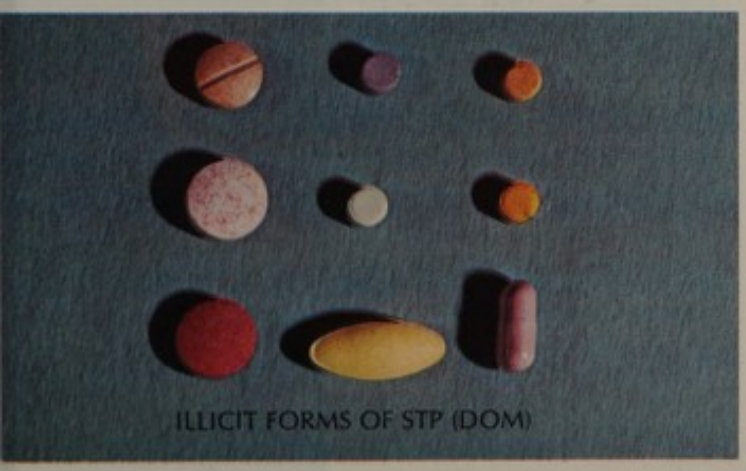
LEGITIMATE DOSAGE FORMS OF
LYSERGIC ACID DIETHYLAMIDE (LSD)



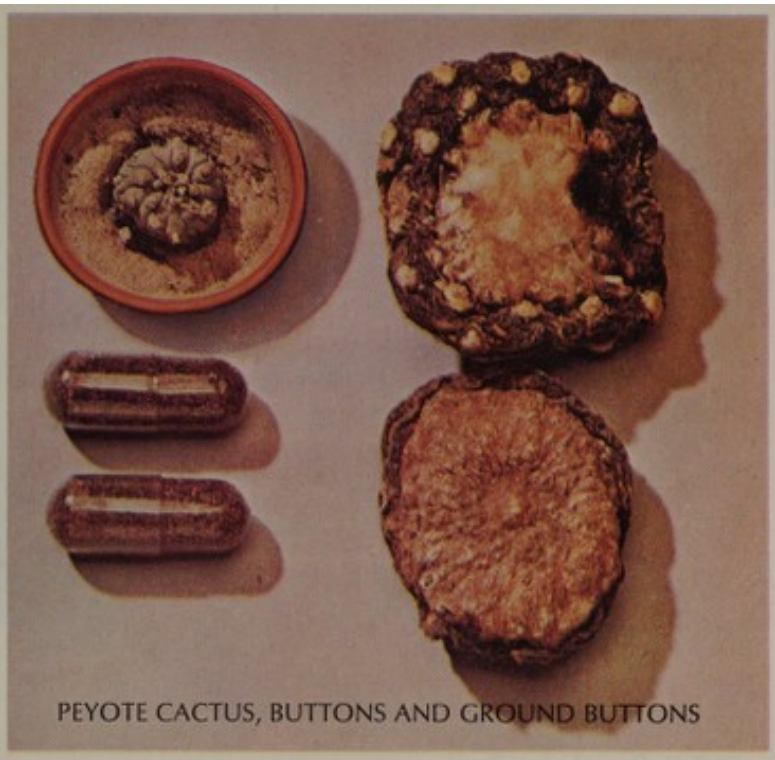
ILLICIT DOSAGE FORMS OF
LYSERGIC ACID DIETHYLAMIDE (LSD)



ILLICIT FORMS OF PHENCYCLIDINE (PCP)

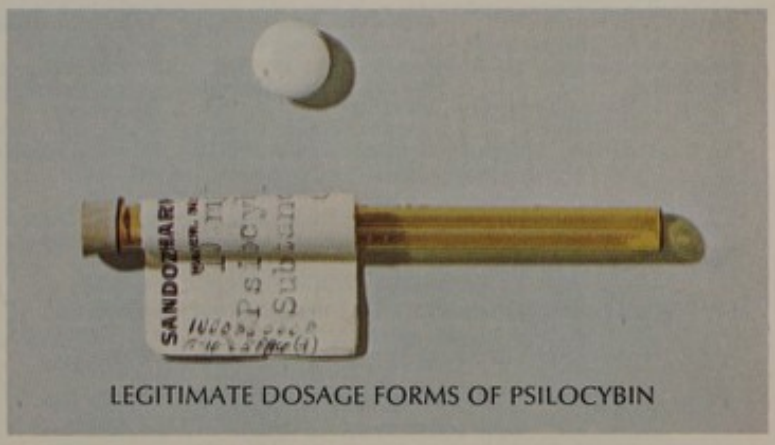


ILLICIT FORMS OF STP (DOM)

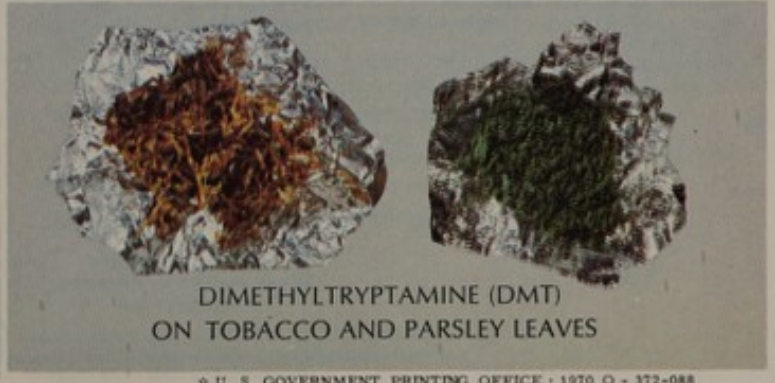


PEYOTE CACTUS, BUTTONS AND GROUND BUTTONS

PSILOCYBE MUSHROOMS



LEGITIMATE DOSAGE FORMS OF PSILOCYBIN



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GLOSSARY OF DRUG TERMS

The following list contains mostly the jargon of the drug world, the slang and terms used by those involved in the drug "scene," but it also includes some fundamental technical terms.

As in the case of any illicit activity, participants in the drug world have traditionally had a language all their own. With the advent of the "Drug Revolution" within the past several years a new dimension has been added to the drug vocabulary.

Whereas today's vernacular retains some of the old terms the majority of the modern terms evolved from a new drug subculture that borrowed from rock music, the ghettoes of our cities, the hipples, and in general, the "cool talk" that spontaneously arose from our teenagers.

The use of slang words by youngsters within peer groups serves two purposes: to provide them with the necessary security and protection from quick identification, and to exclude "outsiders" from the peer group, including the "establishment."

Often, the language of drug abuse is picked up as contemporary slang by non-abusers — particularly teenagers. For this reason, use of many of these terms can not be considered as evidence of drug abuse.

There are, of course, variations in this lexicon as one moves from one part of the country to another. In addition, it is a language which changes often, both in nuance and in terms. With no appreciable sign that the drug problem has peaked, it can be reasonably concluded that many of the slang terms will endure for some time.

We trust this list will be useful to those in and out of government involved in the administration of criminal justice, to educators in their efforts to communicate better in their drug abuse programs, to parents, and everyone else having a vital interest in the drug problem.

We gratefully acknowledge the following sources in the compilation of this list:

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A FEDERAL SOURCE BOOK: ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS ABOUT DRUG ABUSE, National Clearing House for Drug Abuse Information, Washington, D. C., 1970.

GLOSSARY OF SLANG TERMS RELATED TO DRUG ABUSE, by Dr. Albert N. Meyerstein, from TEACHING ABOUT DRUGS: SCHOOL, American Health Association and Pharmaceutical Manufacturers Association, 1970.

DRUG DEPENDENCE AND ABUSE RESOURCE BOOK, National District Attorneys Association, 1971.

HIGH ON THE CAMPUS, by Gordon R. McLean and Haskell Bowen, 1970.

MARIJUANA, by Dr. Edward R. Bloomqust, 1968.

A—
An amphetamine
Ab—
Abscess.
Acapulco Gold—
High grade marihuana from Mexico
Acid—
LSD
Acid Head—
A regular user of LSD
Acid Test—
Party at which LSD has been added to the refreshment punch
Action—
A lot of drugs in the neighborhood; opportunity to make money or obtain drugs; "What's the Action?" i.e. "What's Happening." Also, protection from the police through bribery or other arrangement
Addiction—
In 1957, the World Health Organization (WHO) defined drug addiction as a state of periodic or chronic intoxication produced by the repeated consumption of a drug. Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence on the effects of the drug; (4) an effect detrimental to the individual and to society
African Black.
A strain of marihuana
Amped—
Injectable methamphetamine
Amphetamines—
Stimulants; Bennies, Co-Pilots, Dexies, Dynamites, Eye-Openers, Hearts, Lid Proppers, Marathons, Peaches, Pep pills, Roses, Truck Drivers, Wake-ups, Cartwheels, Footballs, Greenies, Crystal, Meth, Crank, Crink, Cris, Christian, Speed, Bombidos, Bottles, Amped, Jugs, Cross Tops
Amping—
Overdose of drugs, usually heroin.
Amy (Amy Joy)—
Amyl Nitrite
Anascha—
Marihuana (In Russia)
Angel Dust—
Synthesized marihuana
Anywhere—
Possessing drugs
Artillery—
Equipment for injections
Astrol—
The mind taking a "trip" on hallucinogens while the body stays behind
At—
Where drug action is taking place
Babo—
Nalline, a morphine-related substance, used to treat narcotic poisoning from heroin, methadone, or morphine. It is called "babo" since it "takes the user to the cleaner"
Baby—
A girl
Baby Sit—
To guide a person through his drug experience, baby-sitters are usually experienced drug users
Backdoor Artist—
A drug user who specializes in cheating other users.
Backtrack (Backup)—
Withdraw the plunger of a syringe before injecting drugs to make sure needle is in proper place
Backwards—
Tranquilizers
Bad—
Either powerful or weak drugs, depending upon the tone of voice used; A good fighter or an informer, depending on how the word is used
Badge—
Too small an amount for money paid
Bad Go—
To have bought an inferior quality of drug
Bad News—
An uncomfortable or dangerous situation; and untrustworthy person ("He's Bad News")
Bad Scene—
A situation likely to result in unpleasant drug experience or other trouble; anything that is unpleasant
Bad Seed (The)
Peyote
Bag—
A container of drugs; a job; one's particular interest or attachment. "Bagging" means packaging heroin for sale
Bagman—
A drug supplier
Bale—
Pound of marihuana
Ball—
A pleasant happening; absorption of stimulants and cocaine via genitalia
Balloon—
Rubber toy balloon used for storing or delivering heroin. "Ballooning" means packaging heroin for sale
Bang—
An injection of drugs
Banj—
Marihuana (In Middle East)
Barbiturates—
Depressants; Barbs, Candies, Peanuts, Pills, Purple Hearts, Sleeping Pills, Softballs, Blue, Blue Birds, Blue Bullets, Blue Devils, Blue Dolls, Blue Heavens, Double Trouble, Blue Tips, Rainbows, Reds and Blues, Nimbies, Yellows, Yellow Bullets, Yellow Jackets, Pinks, Reds, Red Birds, Red Bullets, Red Devils, Seccies, Seggies, Phennies
Barbs—
Barbiturate drugs
Bash—
Marihuana
Beans—
Benzadrine (amphetamines)
Beast—
LSD
Beat—
Feeling bad, broke, out of narcotics
Beef—
A criminal charge
Been Had—
Arrested or cheated out of something
Be-In—
A collection of people meeting for some specific purpose
Bennie—
An amphetamine
Bernice—
Cocaine
Bhang (Blang)—
Marihuana. (In India)
Big "C"—
Cocaine
Big D—
LSD

Big John—
The police
Big Time (Big Top)—
Maximum term in prison
Bindle—
A small quantity or packet of drugs
Birdseye—
A small amount of narcotics
Biz—
Equipment for injecting drugs
Black—
Opium.
Black and White—
A police patrol car
Black Columbus—
Marihuana
Black Mote—
Marihuana cured in sugar and honey
Blank—
Poor quality heroin; equipment for injections
Blast—
Strong effect from a drug; to smoke marihuana; a good time, a party
Blast Party—
A company of marihuana smokers
Blow—
To smoke marihuana; to leave willingly; to lose an opportunity
Blow a shot—
To spill or lose a shot
Blow a vein—
Unsuccessful attempt to puncture a vein
Blow your cool—
To lose self-control
Blow your mind—
An astonishing or fascinating experience; or on the negative side it may denote a bad trip or an experience
Blue Acid—
LSD
Blue Angels—
Amytal, a barbiturate
Blue Birds—
Amobarbital, a barbiturate
Blue Bands—
Pentobarbital sodium, a barbiturate
Blue Bullets—
Amobarbital, a barbiturate
Blue Cheer—
A type of LSD
Blue Devils—
Amobarbital, a barbiturate
Blue Fascists—
the police
Blue Heavens—
Amobarbital, a barbiturate.
Blues—
Amobarbital, a barbiturate.
Blue Tips—
Amobarbital, a barbiturate.
Blue Velvet—
Paregoric and pyribenzamine (an anti-histamine), mixed and injected
Boast—
To obtain, steal
Bogart—
To "Bogart a joint" is to either salivate on or to retain (and not pass around) a marihuana cigarette (from Humphrey Bogart, the late movie actor)
Bombed—Intoxicated on drugs
Bombidos—
Injectable methamphetamines
Bombitas—
Injectable methamphetamines
Boo—
Marihuana
Boo Hoo—
A "priest" in the hippie Neo-American church
Booster—
Consumption or injection of additional dosage to continue or prolong a "trip"; also, a shoplifter or thief
Boot—
To prolong the injection by advancing the plunger slowly
Boss—
"Groovy"
Bottle Dealer—
A person who sells drugs in 1000 tablet or capsule bottle
Bottles—
Injectable methamphetamine
Box—
A metal container for marihuana
Boxed—
In jail
Boy—
Heroin
Bread—
Money
Brick—
A kilogram of marihuana or hashish in compressed brick form
Bridge—
Usually refers to an alligator clamp or a similar device used to hold marihuana cigarette while smoking it
Browns—
Long acting amphetamines
Brown Shoes—
Name for "squares"
Bug—
To bother or pester someone
Bull horror—
The illusioned fear the drug user has of being observed by the police. A "bull" is the term for a policeman or federal narcotic agent
Bummer—
A bad hallucinogenic trip
Bum Trip—
A bad hallucinogenic trip
Bundle—
A small quantity or packet of narcotics; large amount of money
Burese—
Cocaine
Burned—
To be cheated, to be given bad drugs; to be caught or arrested
Burned out—
A collapsed vein into which it is impossible to inject drug solutions
Burnies—
Marihuana cigarettes
Bush—
Marihuana
Business—
Hypodermic equipment
Businessman's Trip—
DMT
Busted—
Arrested
Butter Flower—
Marihuana
Buttons—
The sections of the peyote cactus

Buzz—
A drug induced "high" or an attempt to make a purchase of drugs
Buzzon—
To feel good
C—
Cocaine
Caballo—
Heroin
Cache—
Secret supply of drugs in a secure place
Cactus—
Peyote; also used on the west coast to signify money
Can—
Car; a container with about 1½ ounces of marihuana; a lid; also refers to a package containing from 3½ to 6½ ounces of heroin
Canamo—
Marihuana (In Spain)
Candies—
Barbiturates
Candy—
Cocaine
Candy Man—
Seller of drugs
Cannabis—
The genus name for all the tetrahydrocannabinol-producing weeds, including marihuana and hashish
Cap—
A capsule; a quantity of heroin
Carga—
Heroin
Cargo—
Load or supply of drugs
Carrying—
Transporting drugs or keeping them on one's person while in transit. See "Holding"
Carry Nation—
Cocaine
Cartwheels—
Double scored amphetamine tablets
Cat—
A conventionally behaving person; one who knows where the action is
Cecil—
Cocaine
Central Nervous System—
The brain and spinal cord
Cents—
Dollars. Then cents is equal to ten dollars
C-Game—
Cocaine
Chalk—
Cocaine
Champ—
Drug user who won't reveal his supplier, even under pressure
Channel—
Blood vessel
Chanvre—
Marihuana. (In France)
Chapters, Sleeping-In—
Just beginning to drowse after withdrawing from heroin addiction
Charas (Charras)—
Marihuana (In India)
Charge—
Marihuana; or anything from which much satisfaction is derived
Charged up—
Under the influence of drugs
Charley—
Cocaine
Chasing the Dragon—
Heating heroin for injection; to inhale heroin and a barbiturate powder through a straw—borrowed from the Chinese expression in Hong Kong of sniffing heroin through a rolled piece of paper
Chicago Green—
A west coast expression for dark green marihuana
Chick—
A sexually desirable young female
Chicken—
Afraid
Chicken out—
To lose one's nerve
Chicken Powder—
Amphetamine powder for injection
Chief (The)—
LSD
Chipping—
Occasional use of opiates
Chippy—
One who takes drugs occasionally, but is not yet dependent on them
Chira—
Marihuana
Chiva—
Narcotics, usually heroin
Chop—
To chop heroin, cocaine or methadrine crystals with a razor blade to remove lumps
Christian—
Methamphetamine
Christmas Tree—
Spansules containing an amphetamine and a barbiturate
Chuck—
Food. A "chuck habit" describes hunger after withdrawing from heroin addiction
Churus (Churrus)—
Marihuana (In India)
Ciemba—
Marihuana (In Brazil)
Cigarettes—
Marihuana cigarettes
Clean—
An addict who is free from narcotic injection marks, or is not in possession of drugs; to remove stems and seeds from marihuana. Dressed sharply. A well-planned crime. Having no warrants for one's arrest
Clear up—
To withdraw from drugs
Coasting—
Under the influence of drugs
Cocaine—
Crystalline powder made from coca leaves grown principally in the Andes Mountain area of South America; known by the following names—Bernice, C., Candy, Carry Nation, Cecil, Chalk, Coke, Coconuts, Corrine, Dust, Flake, Frisky Powder, Sniff, Snow, White Powder
Cocked-up—
To be under the influence of cocaine
Cocktail—
Attaching a marihuana butt to a regular tobacco cigarette
Coconuts—
Cocaine
Cod Cock—
A codeine cocktail, a mixture, 8 to 12 ounces of over-the counter medicines with small codeine content used as cough mixtures

Cohoba—
A snuff, made from powdered seeds of plants grown in the West Indies and parts of South America, that produce DMT, a hallucinogen
Coke—
Cocaine
Cokie—
Cocaine user
Cold—
Tough deal, as "cold heart"
Cold Turkey—
To be undergoing withdrawal symptoms without drugs; to break a drug habit
Columbian Pink—
A potent form of marihuana
Come Down—
To come off of drugs; anything which is not satisfying
Come Home—
To end a drug high
Con—
To swindle
Connect—
To buy drugs
Connection—
A dealer who is known to an addict or buyer
Conrad—
A peddler of pills
Contact—
A source of drugs
Contact High—
A trip caused by the emotional experience of observing or being near someone who is high because of actual drug indulgence
Convulsions—
An involuntary and violent irregular series of contraction of the muscles
Cook—
To prepare heroin for injection; an underground chemist who manufactures illegal speed, LSD and heroin; the term was originally applied to the person who prepared smoking opium for a group of opium smokers
Cook a Pill—
To heat opium for smoking it in a pipe
Cooker—
A bottle cap or spoon in which heroin can be heated
Cooks—
Underground pharmacists who sell drugs without prescription
Cool—
To be indifferent or aloof; to be all right, safe, in tune with what's happening
Cool Chippy—
One who is not as yet dependent on drugs
Cool it—
Don't get excited
Cop—
To get drugs or anything else; to steal
Cop a Plea—
To plead guilty, to confess to anything
Cope—
To maintain while intoxicated on drugs, to handle oneself effectively while under the influence of drugs
Co-Pilots—
Amphetamines
Cop Out—
To discontinue participation, quit, confess, defect, inform
Copped Out—
To be conscious, but showing no interest in one's surroundings
Coral—
Mickey Finn, a choral hydrate solution or capsule
Corgy—
Heroin
Corine (or Corrine)—
Cocaine
Cotics—
Narcotics
Cottons—
Bits of cotton saturated with narcotic solution, used to strain foreign matter when drawing solution up into hypodermic syringe or eyedropper. These cottons often are saved by addicts for an emergency, as they contain a residual amount of the drug. See "Satch Cotton"
Count—
The amount of a drug in a paper or bag
Cowboy—
An independent drug dealer
Crackers—
LSD
Crank—
Methedrine
Crash—
To abruptly discontinue the use of a drug
Crash Pad—
Place where user withdraws from drugs
Crazy—
Exciting, in the know, enjoyable
Creep—
An obnoxious person
Crink—
Amphetamine
Cris—
Methamphetamine
Cristine—
Methadrine in crystal form
Croaker—
A physician
Crooker—
A physician who sells drugs illegally
Cross-Dependence—
To use one barbiturate, or other depressant, to prevent withdrawal symptoms from the regular usage of a different barbiturate
Cross Tops—
Amphetamine tablets
Crumbs—
Money, but in small amounts
Crutch—
A marihuana cigarette holder, usually a split match
Crystal—
Methamphetamine
Crystal Blue Persuader—
Type of hallucinogen, usually LSD, or mescaline
Cube—
Sugar cube impregnated with LSD
Cubehead—
Frequent user of LSD
Cut—
To dilute and adulterate a drug by adding milk sugar or another inert substance
Cut Out—
To leave, depart
Cut Up—
To criticize, put down
CWP—
A marihuana cigarette holder
"D"—
LSD
Dabble (Dauber)—
To take small amounts of drugs on an irregular basis
Dagga—
Marihuana. (In Central Africa)
Dead Time—
To lay around idle

Deal in Weight—
To sell large amounts of drugs
Dealer—
A seller of drugs
Deck—
A packet of drugs
Deeda—
LSD (in New York City's black Harlem)
Delirium—
A condition characterized by mental excitement, confusion, disordered speech and, often, hallucinations
Dependence—
See "Psychological Dependence," "Physical Dependence," and "Drug Dependence"
Depressant—
Any agent that will depress (decrease) a body function or nerve activity. Depressants may be classified according to the organ or system upon which they act
Deuce Bag—
A $2 container of a drug
Dexies—
Dexedrine, an amphetamine
Diamba—
Marihuana. (In Brazil and West Africa)
Dig—
To like, to understand, appreciate, enjoy
Digger—
A Hipple father figure who tries to obtain beds, food, money or employment for needy hipples
Dillies—
An opium derivative
Dime—
Ten dollars; ten years in prison; used instead of number ten. To "Drop a Dime" is to call the police on someone
Dime Bag—
A $10 container of a drug
Dirty—
Possessing drugs, liable to arrest if searched
Ditch—
The inside of the elbow, where large veins can be found for injecting drug solutions
Djamba—
Marihuana (In South Africa)
DMT—
A hallucinogen, also called the "Businessman's trip"
Doe—
Methamphetamine
Dog—
Weak heroin; an unattractive woman; an untrustworthy person; a brutal or hardened policeman; a non-narcotic residue from the opium-refining process
Dog Food—
Bribes for police. judges, etc
Doing—
The taking of a drug, or any "happening"
Doing your thing—
Indulging in one's "bag;" participating in action notably pleasurable to the doer
Dollar—
$100.00
Dolly—
Methadone, a synthetic narcotic
DOM—
STP
Domino—
To purchase drugs
Doojee—
Heroin
Dope—
Opitates; occasionally used to describe any type of drug; synonym for glue used for glue-sniffing; to drug or give any drugs to a person
Doper—
A person who uses drugs regularly
Dotting—
Placing LSD on a sugar cube
Double Cross—
Amphetamine tablets
Double Trouble—
Amobarbital sodium and secobarbital solution (both of which are barbiturates) combined
Do Up—
To inject drugs
Doup—
Smoke a marihuana cigarette, or take an injection of heroin
Down—
Someone or something that depresses a person who is under the influence of drugs
Downers—
Depressant drugs, usually the barbiturates; also used to describe bad trips or drug experiences
Downs—
Depressant drugs, usually the barbiturates
Down Trip—
An unenjoyable or frightening trip
Drag—
A bad trip, a boring happening, a meaningless situation
Dreamer—
Morphine or other narcotic derivatives; one who takes opiates
Dripper—
Eyedropper used for an injection
Drop—
Swallow a drug, usually a capsule, tablet or pill
Drop out—
One who withdraws from society or dispenses with its social mores; the ultimate happening in the psychedelic experience. The term is used both as a noun to denote the doer and as a verb to describe the experience
Dropped—
Arrested
Drug Dependence—
As described in 1963 by WHO, drug dependence is "a state arising from repeated administration of a drug on a periodic or continuous basis." Its characteristics will vary with the agent involved. This is made clear by designating the particular type of drug dependence in each specific case—for example, drug dependence of the morphine type, of the cocaine type, of the cannabis type, of the barbiturate type, etc
Dubbe
Negro slang for a marihuana roach
Dude—
A fellow
Duige—
Heroin
Dumo—
Marihuana. (In South Africa)
Dumping—
Vomiting while high or during withdrawal from drugs
Dummy—
Equipment for injection; or a purchase which did not contain narcotics
Dupe—
To swindle, defraud
Dust—
Cocaine
Dynamite—
Amphetamines; high grade heroin; "groovy"
Ego Games—
A deprecative term applied by LSD users to social

conformity and to normal activities, occupations and responsibilities of the majority of people

Eighth—
An ⅛ ounce of a drug

El Kif—
Marihuana (In Middle East)

Emsel—
Morphine

Ends—
Money

Establishment—
People over the age of 30, usually straight and more often square. Organized society as we know it today

Euphoria—
An often unaccountable feeling of well-being or elation

Explorers Club—
A group of acid heads

Eye Openers—
Amphetamines

Factory—
Equipment for injecting drugs

Fall Out—
Lose consciousness from drugs

Far Out—
Authentically bizarre; avant garde; new, unusual

Fat—
Describing someone who has a good supply of drugs. A "fat doctor" is a practitioner who indiscriminately sells drugs

Fed—
A federal narcotics agent

Fender Benders—
Barbiturates or hallucinogens

Fifteen Cents—
Fifteen dollars

Finding Your Bag—
Doing what seems best to you

Fine Stuff—
Drugs of unusually good quality, only slightly adulterated

Fink—
Informer

Fire up—
Smoking marihuana

Fit—
Equipment for injections

Fix—
An injection of a narcotic, usually heroin or "speed"

Flake—
Cocaine

Flash (Flashing)
A quick jolt felt in the abdomen as the injected drug enters the blood stream. Also describes glue sniffing

Flashback—
Spontaneous reoccurence of an LSD trip without taking the drug. It has also been recently reported that following continued, heavy use of cannabis a "flashback high" can reoccur during periods of abstinence

Flat Time—
Serving a prison term without parole

Flea Powder—
Inferior heroin

Flip (Flip-out)—
Become psychotic from a bad trip or overdose of drugs; also used to denote something that is most pleasurable

Flip Chick—
A crazy girl

Floating—
Under the influence of drugs

Fluff—
See "Chop"

Flunk Out—
To start to use strong drugs

Flush—
A feeling of excitement or pleasure

Flying High—
High on drugs

Flying Saucers—
Morning Glory Seeds

Flynn—
See "Bummer"

Foil—
Small packet of narcotics

Footballs—
Oval shaped amphetamine tablets

Forwards—
Pep pills, specifically amphetamines

Fours—
Aspirin with codeine tablets

Fox—
A pretty woman

Frajo—
Marihuana

Frantic—
Being badly in need of another injection, nervous, jittery

Freak—
To hallucinate; one who has flipped, i.e., one who uses drugs to the point of transcending reality; used to describe a special type of intense abuser of a particular drug, such as "speed freak," or "acid freak." The term of "Jesus freak" has also been applied to describe those in the drug or hipple subcultures who have turned to religion

Freakout—
A bad psychedelic experience, truly to lose all contact with reality

Fresh and Sweet—
Out of jail

Frisky Powder—
Cocaine

Fruit—
A queer; male homosexual

Fruit Salad—
A wide assortment of barbiturates and amphetamines, usually stolen from home medicine cabinets and physicians, placed in a common plate or other receptacle from which persons abstractly choose an assortment to swallow

Full Moon—
A large peyote button

Fuzz—
A "high" from the use of drugs; also a term for policeman

Gage—
Marihuana

Game—
An unnecessary type of behavior designed to impress others. One's way of making money (used on the west coast)

Ganja—
Marihuana (In India)

Garbage—
Inferior heroin; poor quality drugs

Gasket—
A device attached to the dropper tip to prevent air from entering the vein

Gassed Out—
Overcome emotionally by an experience

Gassing—
Sniffing gasoline fumes

Gate-Keeper—
One who initiates another into the use of LSD

Gee—
Intravenous injection. Small piece of paper between eyedropper and needle
Geed Up—
Under the influence of drugs
Gee Heads—
Paregoric users
Geetis—
Money
Geeze (or Geezer)—
Injection of narcotics
General—
Experienced drug user; sometimes ranked by number of stars—"5-star," etc
George—
Ok, all right
Geronimo—
Barbiturates dissolved in an alcoholic beverage
Get High—
The euphoria experienced from a drug injection
Get into something—
To enter into the action, to be involved
Get Off—
To be at the end of a "high"
Getting Down—
Being the first one to fix or use drugs
Ghedis—
Money
Gheid—
Paregoric user
Ghost—
LSD
Gig—
A job, borrowed from the musician's term for a one-night theatrical assignment
Giggle-smoke—
Marihuana smoke
Gimmicks—
The equipment for injecting drugs
Gin—
Cocaine
Girl—
Cocaine
Glad Rag—
A piece of cloth saturated with glue or gasoline, usually a sock. See "Wad"
Glad Stuff—
Favorite drug of addiction
Gluey—
A glue sniffer
Go—
To swing; to participate freely in the drug scene; to perform unusually well; used as a shout of encouragement
Going Up—
Taking drugs to obtain their effect; said of smoking Marihuana or injecting speed, etc
Gold Dust—
Cocaine
Gong—
An opium pipe
Gong Beater—
An opium smoker
Good Go—
A good or reliable dealer in drugs
Good People—
One who can be trusted with drugs
Goods—
Narcotics
Good Trip—
A happy psychedelic experience; sleeping pills
Goofballs—
Sedatives, mainly barbiturates derived from the fact that a heavy dosage gives the user the appearance of being "goofy"
Goofed Up—
Under the influence of barbiturates
Goofer—
One who uses barbiturates
Gow Head—
An opium addict
Graduate—
To start to use stronger drugs
Gram—
A metric measurement; one gram is equal to 15.4 grains; a gram of heroin is equal to 10 capsules
Grapes—
Wine
Grass—
Marihuana.
Grass Brownies—
Cookies containing marihuana or hashish
Grasshopper—
A marihuana smoker
Greenies—
Oval shaped amphetamine tablets
Grefas—
Marihuana
Greta—
Marihuana
Griefo—
Marihuana
Griffo—
Marihuana
Groove—
To concentrate intensely on an object or activity, usually with pleasure
Groover—
One who grooves
Groovy—
An enjoyable activity or person, to feel good and well satisfied
Ground Control—
Caretaker in an LSD session
Guide—
A person assisting and comforting an LSD taker during a trip. See "Baby Sitter."
Gum—
Heroin
Gun—
Needle for injection; one ounce of heroin
Gungeon—
Marihuana originating from Africa. See "Ganja"
Guru—
A person assisting and comforting an LSD taker during a trip
Gut Level—
Emotional depth
"H"—
Heroin
Habit—
Addiction to drugs
Habituation—
As defined by WHO, drug habituation is a condition, resulting from the repeated consumption of a drug, which includes these characteristics: (1) a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being that it engenders; (2) little or no tendency to increase the dose; (3) some degree of psychic dependence on the effect of the drug, but absence of physical dependence and, hence, no abstinence syndrome; (4) a detrimental effect, if any, primarily on the individual

Hag—
An addict using large doses
Hairy—
Heroin
Haium—
Marihuana (In South Africa)
Half Can (Half Lid)—
½ ounce of marihuana
Half Moon—
Peyote
Hallucinogens—
Psychotic drugs that affect the mind in such a way as to produce sensations that are distorted and abnormal in content
Hand to Hand—
Delivery of drugs person-to-person
Hang Out—
To laze around
Hang Up—
A handicap; discomfort; a personal problem; to hallucinate frightening things
Happening—
Action; what's occurring at the moment of interest to the drug group; an exciting or pleasurable event
Happy Dust—
Cocaine
Hard Stuff—
Morphine, heroin or cocaine
Harness Bulls—
Uniformed police officers
Harpoon—
Hypodermic needle
Harry—
Heroin
Has—
Marihuana
Hashbury—
Haight-Ashbury, a district in San Francisco inhabited by drug users
Hashish—
Resin from cannabis
Hawk (The)—
LSD
Hay—
Marihuana
Head—
A frequent user, especially of LSD or methamphetamine; a sensation of the drug's full effect, euphoria
Head Shrinker—
A psychiatrist or psychologist
Hearts—
Amphetamines, usually dexedrine
Heat—
The police
Heaven Dust—
Cocaine
Heavenly Blue—
LSD. Also, Morning Glory seeds
Heavy—
Significant, weighty; highly emotional
Heavy Bread—
Much money
Heeled—
To possess drugs; to be in possession of much money
Helgum—
Marihuana (In South Africa)
Helen—
Heroin.
Hemp—
Marihuana
Hero—
Heroin
Heroin—
A derivative of opium; Boy, Caballo, Corga, Jee Gee, H, Hairy, Harry, Helen, Horse, Joy Powder, Jo Jee, Junk, Schmack, Schmeck, Shit, Scott, Scag, Skag, Skot, Tecata, White Stuff, Dope
High—
Under the influence of drugs
Hike—
A quick transaction
Hikori—
Peyote
Hikuli—
Peyote
Hip—
Advanced in taste or attitude; sophistication; informed
Hit—
A single dose of a drug; an arrest
Hjemu—
Marihuana (In East Africa)
Hocus—
Morphine
Hog—
A drug user who takes all of a drug he can get his hands on. Phencyclidine hydrochloride—a hallucinogen frequently called "Peace Pill" and "PCP"
Hold your Mud—
Hold your ground by remaining silent when questioned by the police
Holding—
To possess drugs
Holding your Mug—
Keeping a secret
Honkte (Hinkey)—
Suspicious of a certain person
Honeymoon Stage—
Period when a heroin user is not yet dependent on the drug
Hooked—
Addicted
Hooker—
A prostitute
Hop Head—
One addicted to opium; also addicted to heroin
Hoppid—
Sub-human creature who lives in Utopia
Horning—
Sniffing a narcotic powder, usually cocaine, up the nose
Horse—
Heroin.
Horse Heads—
Amphetamine tablets
Hot—
Wanted by the police
Hot Shot—
An injection of an impure drug or one of too high a dose; a fatal dosage; poisonous powder sold as heroin to a person suspected of being a police informer, for the purpose of killing him
Huatari—
Peyote
Huffers—
Glue sniffers
Hung Up—
Trapped in a snare of emotional, psychological, or interpersonal problems that prevent one from enjoying drugs or life in general
Hustle—
Activities involved in obtaining money to buy heroin; to precipitate a happening; a prostitute sells her services when she "hustles"
Hustler—
A female prostitute; a male procurer or "pimp"

Hype—
One who uses drugs by injection; short term for hypodermic needle
Hype Outfit—
Equipment for injecting drugs
Hypnotic—
An agent that induces sleep
Ice Cream Habit—
Sporadic use of drugs
Ice Cream Man—
A seller of drugs
Icky—
Beginning to withdraw from heroin addiction; sick
Indian Hay—
Cannabis, specifically Cannabis Indica, or hashish
In Power—
A pusher of drugs
Intravenous Injection—
An injection of a drug solution directly into the veins
"J"—
A marihuana cigarette.
Jab—
To inject drugs
Jack (Jack Off)—
To prolong the injection by advancing the plunger slowly
Jacked Up—
To be interrogated or arrested
Jacket—
Reputation, usually derogatory, as a "snitch jacket," a "punk jacket"
Jacking Off the Spike—
Prolonging the injection by advancing the plunger slowly and allowing blood to reflow into the syringe
Jag—
To add a substance to a drug to achieve a greater effect
Jamming—
Losing one's cool, at a loss for words. A musician is "jamming" when he is improvising and not reading the music
Jar Dealer—
A person who sells drugs in 1000 tablet or capsule bottles
Jay—
A marihuana cigarette
Jee Gee—
Heroin
Jellie Babies—
Amphetamines
Jive—
To lie, cheat; to fool around; marihuana
Job—
To inject drugs
Joint—
A marihuana cigarette; a place where the action is; a prison
Jo Jee—
Heroin
Jolly Beans—
Amphetamines
Jolt—
An injection of narcotics
Joy Pop—
To inject narcotics irregularly
Joy Powder—
Heroin
Jug—
A 1,000 tablet or capsule bottle
Jugs—
Injectable methamphetamines
Juice—
Hard liquor; protection from the police through bribery; criminal usury
Junk—
Heroin
Junkie (Junker)—
A heroin addict
Juvies—
Juvenile offenders
Kaal—
Marihuana (In South Africa)
Kee—
A kilogram
Keg—
A kilogram of marihuana; or a quantity of 25,000 amphetamine capsules, or more
Keif—
Marihuana. (In Middle East)
Keister (Kiester) Plant—
Narcotics secreted in rectum
Key—
A kilogram
Khib—
Marihuana (In Middle East)
Kick—
To overcome drug dependence; a feeling of excitement or pleasure
Kicks—
A drug experience
Kick the Habit—
Stop using narcotics (from the withdrawal leg muscle twitches)
Kif—
Marihuana. (In Middle East)
Kilo—
Abbreviation for kilogram, the metric measurement, equals 2.2 pounds
Kit—
Syringe, needle, bottle cap, and cotton swabs—equipment for drug injections
Kite—
One ounce of marihuana Term also used to denote check forging and passing
Knocked in—
Arrested for marihuana
Knocked Out—
Under the influence of narcotics
"L"—
LSD
"L.A."—
Long-acting amphetamines
Lab—
Equipment used to manufacture drugs illegally
Lace—
Money
Laid Out—
Being informed on
Lame—
Not very smart, dumb, or green; not street-wise
Lame Ones—
Those who need a crutch to cope with reality
Lard—
Police
Las Tres—
Marihuana. (In Mexico)
L. A. Turnabouts—
Amphetamines
Laydown—
A place where opium is smoked
Layout—
Equipment for injecting drugs

Leach—
To beg, to mooch off people

Leaf (The)—
Cocaine

Lean—
A non-drug user

Leaves—
Marihuana

Lemonade—
Poor quality herion

Let it all hang out—
To give the facts, to hide nothing

L'Herbe—
Marihuana (In France)

Lhesca—
Marihuana

Liamba—
Marihuana (In Brazil and South Africa)

Lid—
One ounce of marihuana—about the quanity that will fill the lid of a tobacco tin

Lid Proppers—
Amphetamines

Life the Plant—
Under the influence of drugs

Lift Up—
Under the influence of drugs

Lipton Tea—
Poor quality marihuana, or other forms of drugs

Lit up—
High on drugs

"LL"—
Marihuana.

Loaded—
Under the influence of drugs.

Loco Weed—
Marihuana

Long Green—
Money

Lords—
Dilaudid (hydromorphone)

Love In—
A be-in dedicated to peace and love and, on occasion, cannabis smoking and sex

Love Weed—
Marihuana

Luer—
Hypodermic needle

"M"—
Morphine

Machinery—
Syringe, needle, bottle cap, and cotton swab. Equipment for injection

Machoma—
Marihuana (In Brazil)

Macking—
Pimping for prostitutes

Maconha—
Marihuana (In Brazil)

Magic Mushroom—
Psilocybin.

Magic Pumpkin—
Mescaline.

Mainline—
Vein, to inject a drug solution directly into the vein

Mainliner—
One who uses drugs by intravenous injection

Maintaining—
Keeping at a certain level of drug effect

Majoun—
Marihuana

Make a Buy—
To purchase drugs

Make a Meet—
To purchase drugs; to keep an appointment

Make it—
To purchase drugs; to leave the scene or area

Man—
A dealer of drugs; a police officer; a term of address within the drug group

M and M's—
Seconal, a barbiturate

Manicure—
To prepare marihuana for use in cigarettes by removing stems, seeds and dirt

Manteca—
Marihuana. (In Mexico)

Marathons—
Amphetamines

Marihuana—
Cannabis Sativa; Acapulco Gold, Bash, Bhang, Black Columbus, Charas, Charge, Chicago, Green, Chira, Churus, Frajo, Gage, Ganja, Grass, Grefas, Greta, Hash, Hashish, Hay, Hemp, Heat, J, Jive, Leaves, Lhesca, LL, Majouns, Mary Jane, Mary Warner, Mezz, Mu, Muta, Pot, Tea, Weed, Yesca, Gungeon, Mexican Brown, Panamian Red, Panatella, Meserole, Sas Fras

Marks—
Scars caused by hypodermic needle injections

Mary Jane—
Marihuana

Mary Warner—
Marihuana

Master Key—
A sledgehammer used by the police to break down a door

Mata Kwane—
Marihuana (In Central Africa)

Matchbox—
A small amount of marihuana, sufficient to make between 5 to 8 cigarettes, about a fifth of a lid

Ma-Yo—
Marihuana (In China)

Mbangi—
Marihuana (In Central Africa)

Mbanzha—
Marihuana (In Central Africa)

MDA—
A hallucinogen

Medicine—
Drugs of addiction

Meet—
To buy drugs

Mellow Yellow—
Refers to smoking banana-skins, a hoax as they contain no mind-altering drugs

Melter—
Morphine

Mesc—
Mescaline

Mescaline—
An alkaloid of the peyote cactus

Meserole—
Marihuana from Central or South America

Meth—
Methamphetamine

Meth Head—
Habitual user of methamphetamine

Methadone—
A drug used to replace heroin addiction, employed in government programs of treatment and rehabilitation
Methamphetamines—
A mind-altering drug; Crank, Crink, Cris, Christian, Meth, Bombidos, Bottles, Crystals, Jugs, Speed, Amped, Splash
Meth Freak—
A frequent user of methamphetamine
Meth Head—
A frequent user of methamphetamine
Meth Monster—
A frequent user of methamphetamine
Mexican Brown—
Marihuana
Mezmerizing Eye—
All seeing eye of the LSD user; dot on the center of forehead symbolic of the mezmerizing eye when the wearer is on an LSD trip
Mezz—
Marihuana
Mickey (Mickey Finn)—
Chloral hydrate and alcohol
Mikes—
Micrograms (millionths of a gram); a metric measurement
Mindblower—
An experience or a drug which upsets one's emotional and/or psychological equilibruim; pure, unadulterated drug
Miss—
Failing to hit a vein while injecting a drug
Miss Emma—
Morphine
Mob—
Professional gangsters
Mohasky—
Marihuana
Mojo—
Morphine
Monkey—
Drug habit, dependency; also a term for morphine
Mooch—
A leach, one who begs
Moon—
Peyote
Mor-a-grifa (Moragrita)—
Marihuana
Morphine—
A derivative of opium; Dope, Hard Stuff, Hocus, Mary Ann, Miss Emma, Mojo, Morpho, White Stuff
Morpho—
Morphine
Mota (Moto)
Marihuana (In Mexico and East Africa)
Moto Kwane—
Marihuana (In East Africa)
Motul—
Marihuana (In Mexico)
MU—
Marihuana
Mud—
Opium for smoking
Muggles—
Marihuana cigarettes
Mule—
A boy who delivers narcotics; any kind of a drug dealer courier
Muscle—
To inject intramuscularly
Muta (Mutah)—
Marihuana
Nabs—
Police; get arrested
Nalline—
A morphine-related substance, used to treat narcotic poisoning from heroin, methadone, or morphine; also used in testing whether there are any opiates in the body
Narc (Narco)—
A narcotics detective
Narcotics—
Refers to the natural and synthetic derivatives of opium (morphine, heroin, codeine, etc.)—not a synonym for drugs
Needle—
Hypodermic needle
Needle Flash—
A short high from the needle being inserted, prior to the drug entering the bloodstream
Nickle Bag—
A $5 package of drugs
Nimbies—
Yellow barbiturates, nembutals
Nimby—
A yellow-colored barbiturate, nembutal
Njaga—
Marihuana (In East Africa)
Nod—
To experience relaxation after taking a drug
Nose Freeze—(Nose Habit)
Heroin addiction through repeated inhalation or oral induction of the drug
Noto—
Marihuana (In Spain)
Number—
A marihuana cigarette
Opium
O.D.—
Overdose of drugs
Off—
Withdrawn from drugs
Oil burner—
A narcotics habit requiring large amounts of drugs
On a trip—
Under the influence of LSD or other hallucinogens
On the Beam—
Under the influence of marijuana
On the Needle—
Using hard narcotics; "mainlining"
On the nod—
Sleepy from narcotics or other sedative-type drugs
On the street—
Out of jail
On the Stuff—
Regular user of heroin
Ope—
Opium
Opiate—
A class of drugs which have the properties and actions of opium; includes opium itself and derivatives of opium as synthetic opiate-like drugs not derived from opium
Opium—
The plant which produces the product of the same name, from which the opiate drugs are derived
Oranges—
Dexedrine (amphetamine) tablets.
Outfit—
Injection equipment
Out of it—
Not in contact, not part of the drug scene
Out of sight—
Tremendous, superb, so good it can't be believed, "groovy"

Outside of myself—
Described feelings experienced under the influence of LSD
Owsley's Acid—
LSD purportedly illegally manufactured by Augustus Owsley Stanley III; also infers that it is good quality LSD
Oz—
Refers to an ounce of drugs, usually heroin or methamphetamine
"P"—
Peyote
Pacifier—
A baby's nipple used on top of an eyedropper to force and control the flow of drugs into a vein
Pack—
Heroin
Pad—
Room, dwelling, living quarters
Paddy—
A Caucasian
Panama Red—
A potent type of South American marihuana
Panatella—
Marihuana from Central or South America
Panic—
Scarcity of drugs on the market, usually a temporary situation caused by the arrests of important drug traffickers
Paper—
A container of drugs
Paper Hanger—
One who forges prescriptions or checks
Paradise—
Cocaine
PCP—
Phencyclidine hydrochloride, a hallucinogen; synthetic marihuana
Peace—
STP
Peace Pills—
PCP
Peaches—
Amphetamines
Peanuts—
Barbiturates
Pearly Cakes—
A type of morning glory seed which, if eaten to excess, produces a psychedelic effect
Pearly Gates—
LSD Also, Morning Glory seeds
Peddler—
One who sells drugs
Pen Yen—
Opium
Pep Pills—
Amphetamines, stimulants
Per—
Medical prescription
Perks—
Percodan tablets or capsules, a synthetic opiate
Peter—
Cloral hydrate
Pez—
Pez candles impregnated with LSD
PG—
Paregoric
Phennies—
Barbiturates
Physical Dependence—
Physiological adaptation of the body to the presence of a drug In effect, the body develops a continuing need for the drug. Once such dependence has been established, the body reacts with predictable symptoms if the drug is abruptly withdrawn. The nature and severity of withdrawal symptoms depend on the drug being used and the daily dosage level attained
Piece—
One ounce of drugs, usually heroin or marihuana
Pig—
Derogatory term for police officers; or a drug user who takes all of a drug he can get his hands on
Pill Head (Pill popper — pilly)—
A person who uses pills
Pilly—
Dangerous drug user
Ping the Pill—
To knock off some of the powder from a heroin capsule to spare some for an extra dose
Pink Ladies—
Barbiturates
Pinks—
Secobarbital sodium, barbiturates
Pipe—
A large vein
Plant—
An informer; cache of drugs
Playing the Girls—
Using prostitutes for one's income
PO—
Paregoric
Pod—
Marihuana
Point—
A needle for injection.
Poke—
A puff on a marihuana cigarette
Pop—
To inject drugs To swallow a pill
Popper—
See "Amy"
Pot—
Marihuana
Potentiation—
Potentiation occurs when the combined action of two or more drugs is greater than the sum of the effects of each drug taken alone. Potentiation can be very useful in certain medical procedures. For example, physicians can induce and maintain a specific degree of anesthesia with a small amount of the primary anesthetic agent by using another drug to potentiate the primary anesthetic agent. Potentiation may also be dangerous. For example, barbiturates and many tranquilizers potentiate the depressant effects of alcohol
Pot Likker—
Marihuana tea, usually made with regular tea boiled with marihuana leaves
Pot Head—
A heavy marihuana user
Pot Party—
A company of marihuana users
Powder—
Amphetamine powder
Prickly feeling—
Sensation of air entering a vein while injecting a drug
Probes—
Discussions
Psilocybin—
Sacred mushrooms
Psychedelic—
That which enhances or expands consciousness
Psychological Dependence—
An attachment to drug use which arises from a drug's ability to satisfy some emotional or personality need

of an individual. This attachment does not require a physical dependence, although physical dependence may seem to reinforce psychological dependence. An individual may also be psychologically dependent on substances other than drugs

Psychosis—
A major mental disorder; any serious mental derangement. "Psychosis" replaces the old term "insanity"

Punto—
A hypodermic needle

Pure—
Pure narcotics of very good grade

Purple Haze—
A type of LSD

Purple Hearts—
Barbiturates, usually Dexamyl

Push—
To sell, specifically narcotics and dangerous drugs; to attempt to manipulate one's environment

Push On—
To tease, mock

Pusher—
A seller of drugs

Put down—
Stop taking drugs; as a noun it means something undesirable

Put On—
To tease, mock, fool

Quarter—
A quarter of an ounce of either heroin or methadrine, usually 4 to 8 grams

Quid—
One dollar

Quill—
A matchbook cover used for sniffing or snorting methadrine, cocaine or heroin

Rainbows—
Secobarbital and amobarbital (barbiturates) combined

Rap—
To discuss, inform; to communicate peacefully and/or with purpose

Rare—
To inhale cocaine or heroin through the mouth

Rash—
A feeling of excitement or pleasure

Rasp—
To discuss, talk

Rat (Rata)—
To inform

Rat Fink—
Informer for the police

Reader—
A narcotic or dangerous drug prescription

Red Birds—
Secobarbital sodium, barbiturates

Red and Blues—
Secobarbital and amobarbital combined, barbiturates

Red Bullets—
Secobarbital sodium, barbiturates

Red Devils—
Secobarbital sodium, barbiturates

Reefer—
A marihuana cigarette.

Reentry—
Return from a psychedelic trip

Register—
To wait until blood comes into the hypodermic before injecting a drug intravenously

Riamba—
Marihuana. (In South Africa)

Righteous—
Good quality drugs

Rip Off—
To rob a peddler of his drugs or money

Ripped—
Highly intoxicated on drugs

Roach—
Butt of a marihuana cigarette

Roach Holder—
Device for holding a marihuana cigarette butt

Roll—
A tinfoil wrapped roll of tablets; also a "Roll Deck"

Roll Dealer—
A person who sells tablets in rolls

Rongony—
Marihuana. (In Malagasy)

Rope—
Marihuana

Roses—
Amphetamines

Rough Stuff—
Marihuana as it comes from the plant, not yet manicured

Roust—
An interrogation or arrest

Royal Blue—
LSD

Ruler—
A judge

Run—
An amphetamine binge; to take drugs continuously for at least 3 days. Period during which a drug exerts it euphoric effects

Rush—
The feeling when an injected drug enters the blood stream

Salt—
Heroin

Sam—
A federal narcotics agent

Sas Fras—
North American marihuana

Satch Cottons—
See "Cottons"

Scag—
Heroin

Scarf—
Large appetite that develops after smoking marihuana

Scarf a Joint—
Swallow a marihuana cigarette

Scat—
Heroin

Scene—
The place where the action is, as well as all that is happening at the time. Similar to the scene of a play which portrays all the events of the moment

Schmack—
Heorin

Schmeck—
Heroin

School Boy—
Codeine

Score—
The important facts about a given event or subject; to buy or acquire drugs or sex; to acquire recognition for an accomplishment

Scott—
Heroin.

Script—
A drug prescription

Seccies (Seggies)—
Secobarbital, barbiturates

Sedative—
An agent which quiets or claims activity

Seeds—
Marihuana seeds
Send to Long Beach—
To flush drugs down the toliet before a police raid. (A West Coast expression)
Send to San Pedro—
See "Send to Long Beach"
Seni—
Peyote
Serenity—
STP
Setol—
Marihuana. (In Middle East)
Shine—
Reject
Shira—
Marihuana. (In Middle East)
Shit—
Heroin
Shoot—
To inject drugs
Shooters—
Those who inject drugs
Shooting Gallery—
A place where heroin and amphetamine users convene
Shoot-up—
A series of cocaine injections continuously following each other, possibly lasting a few hours
Short—
A car
Short Sled—
A car
Shot—
An injection of drugs
Shrink—
A psychiatrist or psychologist
Shuck Off—
To fail to do work effectively
Side Effects—
A given drug may have many actions on the body. Usually one or two of the more prominent actions will be medically useful. The others, usually weaker effects, are called side effects. They are not necessarily harmful, but may be annoying
Simple Simon—
Psylocibin, the synthetic equivalent of the Oxacan "Magic Mushroom," an organic psychedelic
Sitter—
A person assisting an LSD taker during a trip
Sixteenth—
Sixteenth of an ounce
Skag—
Heroin
Skin Pop—
To inject drugs under the skin, but not into a vien
Skot—
Heroin
Slammed—
In jail
Sleepers—
Depressant type drugs, usually barbiturates
Sleeping Pills—
Depressant drugs
Sleepy Yen—
Tossing sleep, initiating a "cold turkey" withdrawal
Sleigh Ride—
Using cocaine ("snow")
Smack—
Heroin
Smashed—
Highly drugged, intoxicated. See "Stoned"
Smoke—
Marihuana, particularly on the east coast
Snapped—
See "Amy"
Snatch-and-Grab Junkie—
An unreliable, not too honest addict who sells small quantities of heroin
Sniff—
Inhale a drug through the nose; cocaine
Snipe—
A marihuana cigarette butt
Snitch—
Informer, stoolie
Snort—
Inhale a drug through the nose, usually cocaine
Snow—
Cocaine
Snow Bird—
A cocaine user
Snstangu—
Marihuana (In Central Africa)
Sober Up—
To be at the end of a "high"
Sock it to me—
To tell the straight facts, to speak plainly and honestly
Softballs—
Barbiturates
Sounds—
Music
Source—
Where drugs are obtained; a pusher, dealer, supplier, connection
Spaced—
Very heavily under the influence of drugs
Space Out—
In a daze, particularly a daze resulting from a trip due to the use of psychotoxins
Spatz—
Capsules
Speed—
Stimulants, specifically methamphetamine, a drug capable of producing intense highs with, in most cases, subsequent severe cases
Speedball—
An injection of a stimulant and a depressant, originally heroin and cocaine combined
Speed Demon (Speed Freak)—
A person who uses amphetamines frequently
Speed Palace—
A place rented by an organizer of methamphetamine parties
Spike—
A needle for injection. Also, see "Jag"
Splash—
Methamphetamine; an orgasmic sensation, frequently associated with a penile erection at the beginning of a methamphetamine injection
Splim—
Marihuana
Splints—
Marihuana cigarettes
Split—
To leave, break up with
Spoon—
A quantity of heroin theoretically measured in a teaspoon (usually between one and two grams)
Sport of Gods—
To inhale cocaine through the nose
Spot You—
To pay first and take later delivery of drugs

Spree—
A period of continuous drug taking, drinking bout.
Squares—
Conventionally behaving people; straight-laced; narrow-minded, unimaginative, anti-hip
Ssruma—
Marihuana (In South Africa)
Stack—
A quantity of marihuana cigarettes
Stanley's Stuff—
See "Owsley's Acid"
Star Dust—
Cocaine
Stash—
See "Cache"
Stepped on—
To adulterate a drug
Sticks—
Marihuana cigarettes
Stimulants—
Any of several drugs that act on the central nervous system, producing excitation, alertness and wakefulness
Stomach Habit—
See "Nose Freeze"
Stoned—
Very high on drugs, usually to the point of being unable to cope with reality
Stool Pigeon—
An informer
Stooly—
An informer
Straight—
Not using drugs; unconnected with the drug world; applied to a drug seller who gives a good deal
STP—
A synthetic hallucinogen; initials stand for "serenity, tranquility, peace"
Straw—
Marihuana.
Strawberry Tablets—
Aspirin-sized, pink mescaline tablets
Strung Out—
Dependent on a drug; or describing one who is physically deteriorating
Stuff—
Drugs
Stumblers—
Barbiturates or hallucinogens
Subcutaneous Injection—
An injection of drugs, just under the skin, not into the veins
Suede—
A negro
Suey—
Opium residue in an opium pipe
Sugar—
LSD; any powdered narcotics
Sunshine—
An new form of LSD-25, orange in color
Supplier—
Drug source
Sweeties—
Preludin (British Term), an amphetamine tablet
Sweets—
Amphetamines
Swing—
To be an active and effective participant in the action or happening in the drug and/or the liberal sexual world
Swinger—
One who is an active participant in the drug or sex world
Swingman—
A drug supplier
Syndicate Acid—
STP
Synergism—
See "Potentiation"
"T"—
Marihuana. Also a saccharine or other tablet impregnated with LSD or STP
Tab—
A saccharine or other tablet impregnated with LSD or STP; also an abbreviation for tablet.
Take a Band—
Take drugs
Take Off—
To be ready to inject drugs
Takouri—
Marihuana (In Middle East)
Tall—
A hoodlum
Tar—
Opium
Taste—
A small sample of drugs
Taste of Honey—
Pleasurable experience
TD Caps—
Capsules that disintegrate with the passage of time
Tea—
Marihuana
Tea Blower—
Marihuana smoker
Tea Pad—
A meeting room for marihuana smokers
Tea Party—
A group of marihuana smokers
Tecata (Tecate)—
Heroin
Tennie-Bopper—
Youth from upper or middle class who seeks intensified experience from drugs; formerly applied to an early teenager who liked rock music
Tetrahydrocannabinols—
Identified as the group of substances which are responsible for the psychotoxicity and other pharmacological effects that accrue from the use of the cannabis class of drugs, including marihuana and hashish
Texas Tea—
Marihuana originating from Texas
THC—
Tetrahydrocannabinol
The Hungries—
See "Scarf"
The Man—
Dealer in drugs
Thing—
Heroin; anything that a person likes to do or which he believes he is particularly adapted to do
Thoroughbred—
A high-type hustler who sells pure drugs
Thrill—
A feeling of excitement or pleasure
Ticket Agent—
A seller of drugs
Tie—
A tourniquet used by a drug user prior to taking an injection of drugs. A necktie or any other piece of cloth
Tighten Up—
To turn on, to smoke marihuana
Tingle—
A quick jolt felt in the abdomen at the entrance of the needle into the vein during a drug injection

Toat—
To smoke marihuana
To Be Hep—
To understand
To Be Hip—
To understand
To Have Savvy—
To understand
To Hit On—
To buy drugs
Toke—
To smoke marihuana
Toke Up—
To drag on a marihuana cigarette or a hashish filled pipe
Tolerance—
With many drugs, a person must keep increasing the dosage to maintain the same effect. This characteristic is called tolerance. Tolerance develops with the barbiturates, opiates, amphetamines and related compounds
To Make It—
To buy drugs
Tooies (Tootsies)—
"Tuinal" (brand of amobarbital sodium and secobarbital sodium—barbiturates) capsules
Tools or Works—
Equipment used for injection by hypodermic syringe
Tops—
Peyote
Torch-up—
To light up a marihuana cigarette
Torn Up—
Intoxicated, stoned
Toss—
Search
Toxic Effects (poisoning)—
Any substance in excessive amounts can act as a poison or toxin. With drugs, the margin between the dosage that produces beneficial effects and dosage that produces toxic or poisonous effects varies greatly. Moreover, this margin will vary with the person taking the drug
Toxy—
The smallest container of opium
Toy—
The smallest, metal container of prepared opium
Tracked Up—
Numerous injection marks along the vein
Tracks—
Needle marks, scars along the veins after many injections
Tranquility—
STP
Travel Agent—
A seller of drugs
Tree—
A policeman who accepts bribe money
Trey—
A selling weight of heroin, $3 worth
Trick—
Easy mark, sucker, fool; a prostitute
Trigger—
To smoke a marihuana cigarette immediately after taking LSD
Trim—
Sexual favors from a woman; to cheat in gambling
Trip—
Psychological and physiological sensations perceived after taking an hallucinogen, usually refers to the stronger hallucinogens
Trip Out (Tripping)—
To be high on psychedelic drugs, to immerse oneself in a happening; to become intensely involved
Trips—
LSD
Truck Drivers—
Amphetamines
Tuned in—
To become markedly aware of oneself as a result of mind expansion due to drug use; generally, to be aware of the scene and usually part of it
Turkey—
A package, powder, capsule or pill purported to be narcotics or dangerous drugs but filled with a substance that contains neither; also refers to equipment for injections
Turnabouts—
Long-acting amphetamines
Turn Off—
To dispel interest, to bore, to cause indifference, to withdraw from drugs
Turn On—
To use drugs or to introduce another person to the use of drugs; to come alive; to enter the drug society
Turn On, Tune In, Drop Out—
Take LSD, learn about the "real" world and drop out of the non-drugged world
Turning Tricks—
Prostituting
Turps—
Elixir of terpinhydrate with codeine, a cough syrup
Twenty Five—
LSD
Twist—
Marijuana cigarette
Two Bits—
Twenty five dollars. Words used instead of the number
Uncle—
Federal narcotics agent
Uncool—
One who is aware but incapable (because of hangups or comparable problems) of participating fully in the action. An uncool person may endanger a cool scene because of his lack of self-control and inability to maintain. This is a most uncomplimentary term
Underground—
This is the whole drug subculture, its inhabitants, its activities, its philosophies
Underground Railway—
System which supplies food and lodging to runaway hippies and drug users
Unkie—
Morphine
Up—
To be under the influence of a drug. Usually not in full control of oneself. The person who is "up" is usually sympathetically protected by others in the drug community until he comes down
Uppers—
Stimulants, cocaine and psychedelics
Ups and Downs—
Stimulants and depressants.
Up Tight—
Nervous, anxious, tense, angry
User—
One who uses drugs
Valley—
The inside of the elbow which has two large veins
Vibes (Vibrations)—
Feeling coming from another; may be "good" or "bad" vibrations; mystical sensations
Vic—
Victim of a prostitute thief

Virgin State—
Period when one is taking drugs, but is not yet dependent
Vital Acid—
Pharmeceutical LSD is liquid form
Vodka Acid—
Vodka mixed with LSD
Vongony—
Marihuana (In Malagasy)
Wad—
See "Glad Rag"
Wag—
Cloth soaked with glue for sniffing
Wake Ups—
Amphetamines
Washed Up—
Withdrawn from drugs
Wasted—
Being conscious, but showing no interest in one's surroundings; high or drunk
Way Out—
High on drugs; a wild imagination
Wedding Bells—
LSD
Wedges—
Small tablets of wedge, almost triangular, shape
Weed—
Marihuana
Weekender—
A person who takes drugs only on weekends
Weird—
On drugs.
West Coast Turn Around—
Amphetamine tablets or capsules
Wheels—
A car
Where it's at—
The place, real or imagined, where the action is. To know "where it's at" is to be aware of the drug scene
Whiskers—
A federal narcotics agent
White Girl—
Cocaine
White Powder—
Cocaine
Whites—
Double-scored amphetamine tablets
White Stuff—
Heroin.
Wig—
One's mind
Wig Out—
To undergo a psychotic experience
Wild Geronimo—
Barbiturates dissolved in beer or other alcoholic drinks
Wino—
An alcoholic who prefers wine
Wiped-Out—
To have lost consciousness from use of drugs
Wired—
A dependent; in tune with things
Wishers—
Federal Narcotics Agents
Wokowi—
Peyote
Works—
Syringe, needle, bottle cap, and cotton swab—Equipment for injections
Wrecked—
High on drugs
Yamba—
Marihuana. (In West Africa)
Yard (Y)—
One hundred dollars
Yato—
See "Freak"
Yellow Bullets—
Nembutals, barbiturates
Yellow Jackets—
Nembutals, barbiturates
Yellows—
Nembutals, barbiturates
Yen—
Craving for drugs. A "burning yen" is a marked craving
Yen Hook (Hock)—
Instrument used in opium smoking
Yen Pock—
A ration of opium prepared for smoking
Yen Pop—
Marihuana
Yen Shee—
Opium residue in an opium pipe
Yen Shee Suey—
Yen Shee mixed with wine
Yen Sleep—
A drowsy, restless state during the withdrawal period
Yerba (Yerba Santa)—
Marihuana. (In Central America) "Yerba" is Spanish for "grass," and "Yerba Santa" is Spanish for "Holy Grass"
Yesca—
Marihuana (Spanish)
Youngblood—
A young person using marihuana the first time
Zap—
To destroy
Zen—
LSD
Zig Zag—
Roll-your-own cigarette paper used to make marihuana cigarettes
Zig Zag Man—
Symbol on paper of the same name, coming from picture of man smoking a cigarette, (also symbolic in the hippie culture)
Zonked—
Under the influence of drugs

APPENDIX 1

Illinois Crime Investigating Commission Specific Resolution No. 39

WHEREAS, it is among the purposes of the Illinois Crime Investigating Commission to investigate and establish the facts and general background relating to Organized Crime and individual crimes in so far as they may have a bearing on Organized Crime, and;

WHEREAS, Organized Crime is defined in the Illinois Crime Investigating Commission Act (Illinois Revised Statutes, 1969, Chapter 38, Section 203-2) as any "combination of persons in the commission of crimes," and;

WHEREAS, it is also the purpose of this Commission to evaluate the extent to which Organized Crime exists within the borders of the State of Illinois and the nature of its operations, and;

WHEREAS, it is the further purpose of this Commission to make its findings and evaluations available to the General Assembly for the purpose of future legislation if such should be deemed advisable, and;

WHEREAS, it is the further purpose of this Commission has taken notice of the recent proliferation in the traffic of narcotics and dangerous drugs in this State, and;

WHEREAS, the Commission believes that such drugs may be causing great human damage to the citizens of Illinois and may be a major factor in the rise of individual and Organized Crime in this State, and;

WHEREAS, illicit dealings in narcotics and dangerous drugs have long been a principal element of Organized Crime; therefore, be it

RESOLVED, that pursuant to the Illinois Crime Investigating Commission Act (Illinois Revised Statutes, 1969, Chapter 38, Sections 203-1 through 203-17 as amended) the undersigned members of the Illinois Crime Investigating Commission hereby authorize the Executive Director and members of his staff to conduct such investigations or inquiries as may be required to determine the extent of the transportation, sale, use and possession of narcotics and dangerous drugs and other reasonably related matters as they exist in Illinois. It is further authorized that public hearings be held at such time and place as the Commission may specify for the purpose of reporting such information to the General Assembly and for the purpose of determining whether changes are required in the laws of Illinois in order to protect the public peace and welfare.

Adopted by the undersigned members of the Illinois Crime Investigating Commission at Chicago, Illinois, this 12th day of September, 1970.

Rep Henry J. Hyde
Co-Chairman
Rep. Tobias Barry
Rep. James Y. Carter
Rep. Joseph G. Sevcik
Sen. Albert E. Bennett

Rep. Gerald W. Shea
Co-Chairman
Sen. Daniel Dougherty
Sen. Thad L. Kusibab
Sen. Cecil A. Partee
Sen. Hudson R. Sours

APPENDIX 2

The Illinois Controlled Substances Act

Effective August 16, 1971

AN ACT to establish a uniform system for the control of the manufacture, distribution, and possession of controlled dangerous substances, to establish schedules of controlled dangerous substances, to provide enforcement procedures and penalties for any violations thereof, to establish a commission to coordinate efforts against dangerous substance abuse and develop an educational program for administration in Illinois schools, and to repeal certain Acts therein named.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

ARTICLE I

Section 100. Legislative Intent.

It is the intent of the General Assembly, recognizing the rising incidence in the abuse of drugs and other dangerous substances and its resultant damage to the peace, health and welfare of the citizens of Illinois, to provide a system of control over the distribution and use of controlled substances which will more effectively: (1) limit access of such substances only to those persons who have demonstrated an appropriate sense of responsibility and have a lawful and legitimate reason to possess them; (2) deter the unlawful and destructive abuse of controlled substances; (3) penalize most heavily the illicit traffickers or profiteers of controlled substances, who propagate and perpetuate the abuse of such substances with reckless disregard for its consumptive consequences upon every element of society; (4) acknowledge the functional and consequential differences between the various types of controlled substances and provide for correspondingly different degrees of control over each of the various types; (5) unify where feasible and codify the efforts of this state to conform with the regulatory systems of the Federal government and other states to establish national coordination of efforts to control the abuse of controlled substances; and (6) provide law enforcement authorities with the necessary resources to make this system efficacious.

It is not the intent of the General Assembly to treat the unlawful user or occasional petty distributor of controlled substances with the same severity as the large-scale, unlawful purveyors and traffickers of controlled substances. To this end, guidelines have been provided, along with a wide latitude in sentencing discretion, to enable the sentencing court to order penalties in each case which are appropriate for the purposes of this Act.

Section 101. This Act shall be known as and may be cited as the "Illinois Controlled Substances Act."

Section 102. As used in this Act, unless the context otherwise requires:

(a) "Addict" means any individual who habitually uses any controlled substance so as to endanger the public morals, health, safety or welfare, or who is so far addicted to the use of controlled substances as to have lost the power of self control with reference to his addiction.

(b) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by:

(1) a pracitioner (or, in his presence, by his authorized agent), or

(2) the patient or research subject at the lawful direction of the practitioner.

(c) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseman or employee of the carrier or warehouseman.

(d) "Bureau" means the Bureau of Narcotics and Dangerous Drugs, United States Department of Justice, or its successor agency.

(e) "Control" means to add a drug or other substance, or immediate precursor, to a Schedule under Article II of this Act whether by transfer from another Schedule or otherwise.

(f) "Controlled Substance" means a drug, substance, or immediate precursor in the Schedules of Article II of this Act.

(g) "Dangerous Drugs Advisory Council" means the Dangerous Drug Advisory Council of the State of Illinois or its successor agency.

(h) "Counterfeit Substance" means a controlled substance, which, or the container or labeling of which, without authorization bears the trademark, trade name, or other identifying mark, imprint, number or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person who in fact manufactured, distributed, or dispensed the substance.

(i) "Deliver" or "delivery" means the actual, constructive or attempted transfer of possession of a controlled substance, with or without consideration, whether or not there is an agency relationship.

(j) "Department" means the Department of Law Enforcement of the State of Illinois or its successor agency.

(k) "Department of Corrections" means the Department of Corrections of the State of Illinois or its successor agency.

(l) "Department of Mental Health" means the Department of Mental Health of the State of Illinois or its successor agency.

(m) "Department of Registration and Education" means the Department of Registration and Education of the State of Illinois or its successor agency.

(n) "Depressant" or "stimulant substance" means:

(1) a drug which contains any quantity of (i) barbituric acid or any of the salts of barbituric acid which has been designated as habit forming under section 502 (d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352 (d)); or

(2) a drug which contains any quantity of (i) amphetamine or methamphetamine and any of their optical isomers; (ii) any salt of amphetamine or methamphetamine or any salt of an optical isomer of amphetamine; or (iii) any substance which the Director, after investigation, has found to be, and by rule designated as, habit forming because of its depressant or stimulant effect on the central nervous system; or

(3) lysergic acid diethylamide; or

(4) any drug which contains any quantity of a substance which the Director, after investigation, has found to have, and by rule designated as having, a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect.

(o) "Director" means the Director of the Department of Law Enforcement or his designated agents.

(p) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery.

(q) "Dispenser" means a practitioner who dispenses.

(r) "Distribute" means to deliver, other than by administering or dispensing, a controlled substance.

(s) "Distributor" means a person who distributes.

(t) "Drug" means (1) substances recognized as drugs in the official United States Pharmacopoeia, Official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (2) substances intended for use in diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals; (3) substances (other than food) intended to affect the structure of any function of the body of man or animals and (4) substances intended for use as a component of any article specified in clause (1), (2), or (3) of this subsection. It does not include devices or their components, parts, or accessories.

(u) "Immediate precursor" means a substance:

(1) which the Director has found to be and by rule designated as being a principal compound used, or produced primarily for use, in the manufacture of a controlled substance;

(2) which is an immediate chemical intermediary used or likely to be used in the manufacture of such controlled substance; and

(3) the control of which is necessary to prevent, curtail or limit the manufacture of such controlled substance.

(v) "Local authorities" means a duly organized State, County or Municipal peace unit or police force.

(w) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a controlled substance, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling of its container, except that this term does not include:

(1) by an ultimate user, the preparation or compounding of a controlled substance for his own use; or

(2) by a practitioner, or his authorized agent under his supervision, the preparation, compounding, packaging, or labeling of a controlled substance:

(a) as an incident to his administering or dispensing of a controlled substance in the course of his professional practice; or

(b) as an incident to lawful research, teaching or chemical analysis and not for sale.

(x) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate;

(2) any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), but not including the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salts, compound, derivative, or preparation of coca leaves, and any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocain or ecgonine.

(y) "Nurse" means a registered nurse licensed under the Illinois Nursing Act.

(z) "Official prescription blanks" means the triplicate prescription forms supplied to practitioners by the Department for prescribing Schedule II controlled substances.

(aa) "Opiate" means any substance having an addiction forming or addiction sustaining liability similar to morphine or being capable of conversion into a drug having addiction forming or addiction sustaining liability.

(bb) "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

(cc) "Parole and Pardon Board" means the Parole and Pardon Board of the State of Illinois or its successor agency.

(dd) "Person" means any individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other entity.

(ee) "Pharmacist" means any person who holds a certificate of registration as a registered pharmacist, a local registered pharmacist or a registered assistant pharmacist under the Pharmacy Practice Act.

(ff) "Pharmacy" means any store, ship or other place in which pharmacy is authorized to be practiced under the Pharmacy Practice Act.

(gg) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(hh) "Practitioner" means a physician, dentist, veterinarian, scientific investigator, pharmacist, registered nurse, hospital, laboratory, or pharmacy, or other person licensed, registered, or otherwise lawfully permitted by the United States or this State to distribute, dispense, conduct research with respect to, administer or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

(ii) "Prescriber" means a physician, dentist or veterinarian who issues a prescription.

(jj) "Prescription" means a lawful written or verbal order of a physician, dentist or veterinarian for any controlled substance.

(kk) "Production" or "produce" means manufacture, planting, cultivating, growing, or harvesting of a controlled substance.

(ll) "Registrant" means every person who is required to register under Section 302 of this Act.

(mm) "Registry number" means the number assigned to each person authorized to handle controlled substances under the laws of the United States and of this State.

(nn) "State" includes the State of Illinois and any state, district, commonwealth, territory, insular possession thereof, and any area subject to the legal authority of the United States of America.

(oo) "Ultimate user" means a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for administering to an animal owned by him or a member of his household.

ARTICLE II

Section 201. (a) The Department shall carry out the provisions of this Article. The Director, with the concurrence and approval of the Dangerous Drugs Advisory Council or its successor agency may add substances to or delete or reschedule all controlled substances in the Schedules of Sections 204, 206, 208, 210 and 212 of this Act. In making a determinization regarding a substance, the Director and the Dangerous Drugs Advisory Council shall consider the following:

(1) the actual or relative potential for abuse;

(2) the scientific evidence of its pharmacological effect, if known;

(3) the state of current scientific knowledge regarding the substance;

(4) the history and current pattern of abuse;

(5) the scope, duration, and significance of abuse;

(6) the risk to the public health;

(7) the potential of the substance to produce psychological or physiological dependence;

(8) whether the substance is an immediate precursor of a substance already controlled under this Article;

(9) the immediate harmful effect in terms of potentially fatal dosage; and

(10) the long-range effects in terms of permanent health impairment.

(b) After considering the factors enumerated in subsection (a) the Director shall make findings with respect thereto and issue a rule controlling the substance if he finds the substance has a potential for abuse. No rule adding, deleting or rescheduling a controlled substance shall have any effect prior to the concurrence of the Dangerous Drugs Advisory Council. Each such rule shall then be submitted to the General Assembly, in the form of a proposed law amending this Act, and unless the proposed law is adopted by the General Assembly and enacted into law within 2 years after the Director has issued the rule, such rule shall expire and have no further force and effect.

(c) If the Director designates a substance as an immediate precursor, substances which are precursors of the controlled precursor shall not be subject to control solely because they are precursors of the controlled precursor.

(d) If any substance is designated, rescheduled, or deleted as a controlled substance under Federal law and notice thereof is given to the Director, the Director shall similarly control the substance under this Act after the expiration of 30 days from publication in the Federal Register of a final order designating a substance as a controlled substance or rescheduling or deleting a substance, unless within that 30 day period the Director objects, or a party adversely affected files with the Director substantial written objections objecting to inclusion, rescheduling, or deletion. In that case, the Director shall publish the reasons for objection or the substantial written objections and afford all interested parties an opportunity to be heard. At the conclusion of the hearing, the Director shall publish his decision, by means of a rule, which shall be final unless altered by statute. Upon publication of objections to inclusion, rescheduling or deletion under this Act by the Director, control under this Act is stayed until the Director publishes his ruling.

(e) The Director shall by rule exclude any non-narcotic substances from a schedule if such substance may, under the Federal Food, Drug and Cosmetic Act, be lawfully sold over the counter without a prescription.

(f) Dextromethorphan shall not be deemed to be included in any schedule by reason of enactment of this title unless controlled after the date of such enactment pursuant to the foregoing provisions of this section.

(g) Authority to control under this section does not extend to distilled spirits, wine, malt beverages, or tobacco as those terms are defined or used in The Liquor Control Act and the Tobacco Products Tax Act.

Section 202. The controlled substances listed or to be listed in the schedules in sections 204, 206, 208, 210 and 212 are included by whatever official, common, usual, chemical, or trade name designated.

Section 203. The Director shall issue a rule scheduling a substance in Scedule I if he finds that:

(1) the substance has high potential for abuse; and

(2) the substance has no currently accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision.

Section 204. (a) The controlled substances listed in this section are included in Schedule I.

(b) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Acetylmethadol or its isomers including Alpha-acetylmethadol, and Beta-acetylmethadol;
(2) Allylprodine;
(3) Alphameprodine;
(4) Dimepheptanol (Methadol, Bimethadol) or its isomers including Alphamethadol, Betamethadol;
(5) Benzethidine;
(6) Betameprodine;
(7) Betaprodine;
(8) Clonitazene;
(9) Dextromoramide including Levomoramide and Racemoramide;
(10) Dextrorphan;
(11) Diampromide;
(12) Thiambutene (Diethylthiambutene);
(13) Dimenoxadol;
(14) Dimethylthiambutene (Aminobutene);
(15) Dioxaphetylbutyrate;
(16) Dipipanone (Pipadone);
(17) Ethylmethylthiambutene;
(18) Etonitazene;
(19) Carbetidine (Etoxeridine);
(20) Furethidine;
(21) Bemidone (Hydroxypethidine);
(22) Ketobemidone;
(23) Levophenacylmorphan;
(24) Morpheridine;
(25) Noracymethadol;
(26) Norlevorphanol;
(27) Normethadone (Mepidon);
(28) Norpipanone;
(29) Phenadoxone (Morphodone, Heptone);
(30) Phenampromide;
(31) Phenomorphan;
(32) Phenoperidine;
(33) Pirinitramide;
(34) Proheptazine;
(35) Properidine (Ipropethidine);
(36) Trimeperidine;

(c) Any of the following opium derivatives, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:

(1) Acetyldihydrocodeine;
(2) Benzylmorphine;
(3) Codeine methylbromide (Eucodin);
(4) Codeine N-Oxide;
(5) Cyprenorphine;
(6) Desomorphine;
(7) Dihydromorphine;
(8) Etorphine and its salts including acetorphine;
(9) Heroin;
(10) Oxymorphone (Hydromorphinol);
(11) Methyldihydromorphine;
(12) Morphine methylbromide;
(13) Morphine methylsulfonate;
(14) Morphine N-Oxide;
(15) Myrophine;
(16) Nicocodeine;
(17) Morphinedinicotinate (Nicomorphine);
(18) Normophine;
(19) Pholcodine;
(20) Dihydrocodeninone Enol Acetate;
(20) Dihydrocodeninone Enol Acetate; Acetyldihydrocodeinone (Thebacon);
(21) Diacetyldihydromorphine (Dihydroheroin);

(d) Any material compound, mixture or preparation which contains any of the following hallucinogenic substances, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3,4-methylenedioxyamphetamine (alpha-methyl, 3, 4-methylenedioxyphen-ethylamine, methylenedioxyamphetamine, MDA);
(2) 3-methoxy-4, 5-methylenedioxyamphetamine, MMDA;
(3) 3, 4, 5-trimethoxyamphetamine (TMA);
(4) 5-hydroxydimethyltryptamine (Bufotenine);
(5) Diethyltryptamine (DET);
(6) Dimethyltryptamine (DMT);
(7) 4-methyl, 2, 5-dimethoxyamphetamine (DOM, STP);
(8) Ibogaine;
(9) Lysergic acid diethylamide;
(10) 3, 4, 5-trimethoxyphenethylamine (Mescaline);
(11) Peyote;
(12) N-ethyl-3-piperidyl benzilate (JB 318);
(13) N-methyl-3-piperidyl benzilate;
(14) Psilocybin;
(15) Psilocyn;
(16) Alpha-methyltryptamine (AMT);

Section 205. The Director shall issue a rule scheduling a substance in Schedule II if he finds that:

(1) the substance has high potential for abuse;

(2) the substance has currently accepted medical use in treatment in the United States, or currently accepted medical use with severe restrictions; and

(3) the abuse of the substance may lead to severe psychological or physiological dependence.

Section 206. (a) The controlled substances listed in this section are included in Schedule II.

(b) Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis;

(1) opium and opiates, and any salt, compound, derivative or preparation of opium or opiate;

(2) any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1), but not including the isoquinoline alkaloids of opium;

(3) Opium poppy and poppy straw;

(4) Coca leaves, cocaine and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves, which extractions do not contain cocaine or ecgonine.

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Alphaprodine;
(2) Anileridine;
(3) Bezitramide;
(4) Dihydrocodeine;
(5) Diphenoxylate;
(6) Fentanyl;
(7) Isomethadone;
(8) Levomethorphan;

(9) Levorphanol (Levorphan);
(10) Metazocine;
(11) Methadone;
(12) Methadone-Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane;
(13) Moramide-Intermediate, 2-methyl-3-Morpholino-I, I-diphenylpropane-carboxylic acid;
(14) Pethidine;
(15) Pethidine-Intermediate-A, 4-cyano-I-methyl-4-phenylpiperidine;
(16) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine 4-carboxylate;
(17) Pethidine-Intermediate-C, I-methyl-4-phenylpiperidine-4-carboxylic acid;
(18) Phenazocine;
(19) Piminodine;
(20) Racemethorphan;
(21) Racemorphan.

(d) Any substance which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.

Section 207. The Director shall issue a rule scheduling a substance in Schedule III if he finds that:

(1) the substance has a potential for abuse less than the substances listed in Schedule I and II;
(2) the substance has currently accepted medical use in treatment in the United States; and
(3) abuse of the substance may lead to moderate or low physiological dependence or high psychological dependence.

Section 208. (a) The controlled substances listed in this section are included in Schedule III.

(b) Any material, compound, mixture or preparation which contains any quantity of the following substance having a potential for abuse associated with a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
(2) phenmetrazine and its salts;
(3) methylphenidate.

(c) Unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid;
(2) Chlorhexadol;
(3) Glutethimide;
(4) Methyprylon;
(5) Sulfondiethylmethane;
(6) Sulfonethylmethane;
(7) Sulfonmethane;
(8) Phencyclidine (PCP);
(9) Lysergic acid;
(10) Lysergic acid amide.

(d) Nalorphine.

(e) Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;
(2) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active non-narcotic ingredients in recognized therapeutic amounts;
(3) not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;
(4) not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts;
(5) not more than 1.8 grams of dihydrocodeine, or any of its salts per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts;
(6) not more than 300 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts;
(7) not more than 100 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts;
(8) not more than 50 milligrams of morphine, or any of its salts, per 100 milliliters or per 100 grams with one or more active, non-narcotic ingredients in recognized therapeutic amounts.

(f) Paregoric.

(g) The Director may except by rule any compound, mixture, or preparation containing any stimulant or depressant substance listed in subsections (b) and (c) from the application of all or any part of this Act if the compound, mixture, or preparation contains one or more active medicinal ingredients having a stimulant or depressant effect on the central nervous system, and if the admixtures are included therein in combinations, quantity, proportion, or concentration therein in combinations, quantity, proportion, or concentration that vitiate the potential for abuse of the substances which have a stimulant or depressant effect on the central nervous system.

Section 209. The Director shall issue a rule scheduling a substance in Schedule IV if he finds that:

(1) the substance has a low potential for abuse relative to substances in Schedule III;
(2) the substance has currently accepted medical use in treatment in the United States; and
(3) abuse of the substance may lead to limited physiological dependence or psychological dependence relative to the substance in Schedule III.

Section 210. (a) The controlled substances listed in this section are included in Schedule IV.

(b) Any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) Barbital;
(2) Chloral betaine;
(3) Chloral hydrate;
(4) Ethchlorvynol;
(5) Ethinamate;
(6) Methohexital;
(7) Meprobamate;
(8) Mephobarbital (Methylphenobarbital);
(9) Paraldehyde;
(10) Pentaerythritol Chloral (Petrichloral);
(11) Phenobarbital.

(c) The Director may except by rule any compound, mixture, or preparation containing any depressant substance listed in subsection (b) from the application of all or any part of this Act if the compound, mixture, or preparation contains one or more active medicinal ingredients not having a depressant effect on the central

nervous system, and if the admixtures are included therein in combinations, quantity, proportion, or concentration that vitiate the potential for abuse of the substances which have a depressant effect on the central nervous system.

Section 211. The Director shall issue a rule scheduling a substance in Schedule V if he finds that:

(1) the substance has low potential for abuse relative to the controlled substances listed in Schedule IV;

(2) the substance has currently accepted medical use in treatment in the United States; and

(3) abuse of the substance may lead to limited physiological dependence or psychological dependence relative to the substances in Schedule IV.

Section 212. (a) The controlled substances listed in this section are included in Schedule V.

(b) Any compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, which also contains one or more non-narcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation, valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) not more than 200 milligrams of codeine, or any of its salts, per 100 millilliters or per 100 grams;

(2) not more than 100 milligrams of dihydrocodeine; or any of its salts, per 100 millliliters or per 100 grams;

(3) not more than 100 milligrams of ethylmorphine, or any of its salts, per 100 millliliters or per 100 grams;

(4) not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) not more than 2 grains of opium, except that preparations containing opium which would otherwise be exempted, shall be subject to those provisions of the Act which require a prescription for the dispensing of Schedule V controlled substances in a retail drug store unless they contain non-narcotic medicinal ingredients which prevent the extraction of the opium with relative technical simplicity. Paregoric shall not be deemed to contain such ingredients unless the paregoric is contained in manufactured products such as Donnagel-P G and Parepectolin.

(c) Any compound, mixture or preparation which contains any quantity of any controlled substance when such compound, mixture or preparation is not otherwise controlled in Schedules I, II, III or IV.

Section 213. The Department shall revise and republish the Schedules semi-annually for two years from the effective date of this Act, and thereafter annually. If the Director fails to republish the Schedules, the last published Schedules shall remain in full force and effect.

ARTICLE III

Section 301. The Department of Registration and Education, in consultation with the Department of Law Enforcement, may promulgate rules and charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances within this State.

Section 302. (a) Every person who manufactures, distributes, or dispenses any controlled substance within this State or who proposes to engage in the manufacture, distribution, or dispensing of any controlled substance within this State, must obtain annually a registration issued by the Department of Registration and Education in accordance with its rules.

(b) Persons registered by the Department of Registration and Education under this Act to manufacture, distribute, or dispense controlled substances may possess, manufacture, distribute, or dispense those substances to the extent authorized by their registration and in conformity with the other provisions of this Article.

(c) The following persons need not register and may lawfully possess controlled substances under this Act:

(1) an agent or employee of any registered manufacturer, distributor, or dispenser of any controlled substance if he is acting in the usual course of his employer's lawful business or employment;

(2) a common or contract carrier or warehouseman, or an agent or employee thereof, whose possession of any controlled substance is in the usual lawful course of such business or employment;

(3) an ultimate user or a person in possession of any controlled substance pursuant to a lawful prescription of a practitioner or in lawful possession of a Schedule V substance;

(4) officers and employees of this State or of the United States while acting in the lawful course of their official duties which requires possession of controlled substances.

(d) A separate registration is required at each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances.

(e) The Department of Registration and Education or the Department of Law Enforcement may inspect the controlled premises, as defined in Section 502 of this Act, of a registrant or applicant for registration in accordance with this Act and the rules promulgated hereunder.

Section 303. (a) The Department of Registration and Education shall register an applicant to manufacture, distribute or dispense controlled substances included in Sections 204, 206, 208, 210 and 212 of this Act unless it determines that the issuance of that registration would be inconsistent with the public interest. In determining the public interest, the Department of Registration and Education shall consider the following:

(1) maintenance of effective controls against diversion of controlled substances into other than lawful medical, scientific, or industrial channels;

(2) compliance with applicable Federal, State and local law;

(3) any convictions of the applicant under any law of the United States or of any State relating to any controlled substance;

(4) past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion;

(5) furnishing by the applicant of false or fraudulent material in any application filed under this Act;

(6) suspension or revocation of the applicant's Federal registration to manufacture, distribute, or dispense controlled substances as authorized by Federal law;

(7) whether the applicant is suitably equipped with the facilities appropriate to carry on the operation described in his application;

(8) whether the applicant is of good moral character or, if the applicant is a partnership, association, corporation or other organization, whether the partners, directors, governing committee and managing officers are of good moral character; and

(9) any other factors relevant to and consistent with the public health and safety.

(b) No registration shall be granted to or renewed for any person who has within 5 years been convicted

of a willful violation of any law of the United States or any law of any State relating to controlled substances, or who is found to be deficient in any of the matters enumerated in subsections (a) (1) through (a) (8).

(c) Registration under subsection (a) does not entitle a registrant to manufacture, distribute or dispense controlled substances in Schedules I or II other than those specified in the registration.

(d) Practitioners must be registered to dispense any controlled substances in Schedules II through V if they are authorized to dispense or conduct research with controlled substances under the law of this State.

(e) If an applicant for registration is registered under the Federal law to manufacture, distribute or dispense controlled substances, upon filing a completed application for registration in this State and payment of all fees due hereunder, he shall be registered in this State to the same extent as his Federal registration, unless, within 30 days after completing his application in this State, the Department of Registration and Education notifies the applicant that his application has not been granted. A practitioner who is in compliance with the Federal law with respect to registration to dispense controlled substances in Schedules II through V need only send a current copy of that Federal registration to the Department of Registration and Education and he shall be deemed in compliance with the registration provisions of this State.

(f) The fee for registration as a manufacturer or wholesale distributor of controlled substances shall be $50.00 per year, except that the fee for registration as a manufacturer or wholesale distributor of controlled substances that may be dispensed without a prescription under this Act shall be $15.00 per year. Each such registration shall expire on the 31st day of December of each year.

Section 304. (a) A registration under Section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Department of Registration and Education upon a finding that the registrant:

(1) has furnished any false or fraudulent material information in any application filed under this Act; or

(2) has been convicted of a felony under any law of the United States or any State relating to any controlled substance; or

(3) has had suspended or revoked his Federal registration to manufacture, distribute, or dispense controlled substances; or

(4) has been convicted of bribery, perjury, or other infamous crime under the laws of the United States or of any State; or

(5) has violated any provision of this Act or any rules promulgated hereunder, whether or not he has been convicted of such violation.

(b) The Department of Registration and Education may limit revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

(c) The Department of Registration and Education shall promptly notify the Bureau and the Department of Law Enforcement or their successor agencies, of all orders denying, suspending or revoking registration, all forfeitures of controlled substances, and all final court dispositions, if any, of such denials, suspensions, revocation or forfeitures.

(d) If Federal registration of any registrant is suspended, revoked, refused renewal or refused issuance, then the Department of Registration and Education shall issue a notice and conduct a hearing in accordance with Section 305 of this Act.

Section 305. (a) Before denying, refusing renewal of, suspending or revoking a registration, the Department of Registration and Education shall serve upon the applicant or registrant, by registered mail at the address in the application or registration or by any other means authorized under the Civil Practice Act or Rules of the Illinois Supreme Court for the service of summons or subpoenas, a notice of hearing to determine why registration should not be denied, refused renewal, suspended or revoked. The notice shall contain a statement of the basis therefore and shall call upon the applicant or registrant to appear before the Department of Registration and Education at a reasonable time and place. These proceedings shall be conducted in accordance with the provisions of the "Civil Administrative Code of Illinois," Sections 60, 60a, 60b, 60c, 60d, 60e, 60f, and 60h, as those sections now exist or shall be amended from time to time, without regard to any criminal prosecution or other proceeding. Except as authorized in subsection (b), proceedings to refuse renewal or suspend or revoke registration shall not abate the existing registration which shall remain in effect until the Department of Registration and Education has held the hearing called for in the notice and found that the registration shall no longer remain in effect.

(b) If the Department of Registration and Education finds that there is an imminent danger to the public health or safety by the continued manufacture, distribution or dispensing of controlled substances by the registrant, the Department of Registration and Education may, upon the issuance of a written ruling stating the reasons for such finding and without notice or hearing, suspend such registrant. The suspension shall continue in effect for not more than 14 days during which time the registrant shall be given an opportunity to be heard. If after the hearing the Department of Registration and Education finds that the public health or safety requires the suspension to remain in effect it shall so remain until the ruling is terminated by its own terms or subsequent ruling or is dissolved by a court of competent jurisdiction upon determination that the suspension was wholly without basis in fact and law.

(c) If, after a hearing as provided in subsection (a), the Department of Registration and Education finds that a registration should be refused renewal, suspended or revoked, a written ruling to that effect shall be entered. The Department of Registration and Education's ruling shall remain in effect until the ruling is terminated by its own terms or subsequent ruling or is dissolved by a court of competent jurisdiction upon a determination that the refusal to renew suspension or revocation was wholly without basis in fact and law.

Section 306. Every practitioner and person registered to manufacture, distribute or dispense controlled substances under this Act shall keep records and maintain inventories in conformance with the recordkeeping and inventory requirements of the laws of the United States and with any additional rules and forms issued by the Department of Registration and Education.

Section 307. Controlled substances in Schedules I and II shall be distributed by a registrant to another registrant only pursuant to a written order. Compliance with the laws of the United States respecting order forms shall be deemed compliance with this Section.

Section 308. Every practitioner who issues a prescription for a controlled substance in Schedule II shall issue such prescription on official prescription forms which shall be issued by the Department of Law Enforcement except as otherwise provided in this act. The prescription forms issued by the Department of Law Enforcement shall be in serial numbered groups of 100 forms, each in triplicate, and shall be furnished at the

cost of $3.00 per group to such practitioner and such prescription forms shall not be transferable. The prescription forms shall be printed on distinctive paper, serial number of the group being shown on each form and also each form being serially numbered. No more than one such prescription group shall in any case be issued or furnished by the Department to the same prescriber at one time.

Section 309. No person shall issue a prescription for Schedule II controlled substances other than on the official prescription form issued by the Department of Law Enforcement and no person shall fill any such prescription other than on the official prescription form issued by the Department of Law Enforcement; provided that in the case of an epidemic or a sudden or unforeseen accident or calamity, the prescriber may issue a lawful oral prescription or a written prescription on a form other than the official prescription form issued by the Department of Law Enforcement where failure to issue such a prescription might result in loss of life or intense suffering, but such prescription shall have endorsed thereon by the prescriber a statement concerning the accident or calamity, or circumstances constituting the emergency, the cause for which the unofficial form was used. All prescriptions on the official forms shall be written in triplicate and all three copies signed by the prescriber. No prescription for a Schedule II controlled substance may be refilled.

Section 310. The official prescription forms containing the prescriber's copies of official prescriptions issued shall be retained by the prescriber and shall be preserved for 2 years and shall at all times be open to inspection by any officer or employee engaged in the enforcement of this Act. If any official prescription forms are lost or stolen, such loss shall be reported to the local authorities and the Department of Law Enforcement as soon as such loss is discovered.

Section 311. The original and one copy of the official prescription shall be delivered to the person filling the prescription. The duplicate shall be properly endorsed by the person filling the prescription at the time such prescription is filled, with his own signature and the date of filling. The original official prescription form shall be retained by the person filling the prescription and by the 15th of the month following the month in which the prescription was filled, the duplicate shall be returned to the Department of Law Enforcement.

Section 312. (a) A practitioner, in good faith, may dispense Schedule II controlled substances to any person upon an official prescription form and Schedule III, IV, or V controlled substances to any person upon a written prescription of any practitioner, dated and signed by the person prescribing on the day when issued and bearing the name and address of the patient for whom, or the owner of the animal for which the controlled substance is dispensed, and the full name, address and registry number under the laws of the United States relating to controlled substances of the person prescribing, if he is required by those laws to be registered. If the prescription is for an animal it shall state the species of animal for which it is ordered. The practitioner filling the prescription shall write the date of filling and his own signature on the face of the prescription form. The official prescription form or the written prescription shall be retained on file by the practitioner who filled it or pharmacy in which the prescription was filled for a period of 2 years, so as to be readily accessible for inspection or removal by any officer or employee engaged in the enforcement of this Act. Whenever the practitioner's or pharmacy's copy of any prescription form is removed by an officer or employee engaged in the enforcement of this Act, for the purpose of investigation or as evidence, such officer or employee shall give to the practitioner or pharmacy a receipt in lieu thereof. A written prescription for Schedule III, IV, or V controlled substances shall not be filled or refilled more than 6 months after the date thereof or refilled more than 5 times unless renewed, in writing, by the practitioner.

(b) In lieu of a written prescription required by this Section, a pharmacist, in good faith, may dispense Schedule III, IV, or V substances to any person upon a lawful oral prescription of a practitioner which oral prescription shall be reduced promptly to writing by the pharmacist and such written memorandum thereof shall be dated on the day when such oral prescription is received by the pharmacist and shall bear the full name and address of the ultimate user for whom, or of the owner of the animal for which the controlled substance is dispensed, and the full name, address, and registry number under the law of the United States relating to controlled substances of the practitioner prescribing if he is required by those laws to be so registered, and the pharmacist filling such oral prescription shall write the date of filling and his own signature on the face of such written memorandum thereof. The written memorandum of the oral prescription shall be retained on file by the proprietor of the pharmacy on which it is filled for a period of not less than two years, so as to be readily accessible for inspection by any officer or employee engaged in the enforcement of this Act in the same manner as a written prescription. The oral prescription and the written memorandum thereof shall not be filled or refilled more than 6 months after the date thereof or be refilled more than 5 times, unless renewed, in writing, by the practitioner.

(c) A controlled substance included in Schedule V shall not be distributed or dispensed other than for a medical purpose and not for the purpose of evading this Act, and then:

(1) only personally by a person registered to dispense a Schedule V controlled substance and then only to his patients, or

(2) only personally by a pharmacist, and then only to a person over 21 years of age who has identified himself to the pharmacist by means of 2 positive documents of identification.

(3) the dispenser shall record the name and address of the purchaser, the name and quantity of the product, the date and time of the sale, and the dispenser's signature.

(4) no person shall be dispensed more than 120 milliliters or more than 120 grams of any Schedule V substance which contains codeine, dihydrocodeine, or any salts thereof, or ethylmorphine, or any salts thereof, in any 96 hour period. The purchaser shall sign a form, approved by the Department of Law Enforcement, attesting that he has not purchased any Schedule V controlled substances within the immediately preceding 96 hours.

(5) a copy of the records of sale, including all information required by paragraph (3), shall be forwarded to the Director by the 15th day of the following month.

(6) all records of purchases and sales shall be maintained for not less than 2 years.

(7) no person shall obtain or attempt to obtain within any consecutive 96 hour period any Schedule V substances of more than 120 milliliters or more than 120 grams containing codeine, dihydrocodeine or any of its salts, or ethylmorphine or any of its salts. Any person obtaining any such preparations or combination of preparations in excess of this limitation shall be in unlawful possession of such controlled substance.

(8) a dispenser registered under this Act shall at no time maintain or keep in stock a quantity of Schedule V controlled substances defined and listed in Section 212 (b) (1), (2) or (3) in excess of 4.5 liters for each sub-

stance plus the additional quantity of controlled substances necessary to fill the largest number of prescription orders filled by that dispenser for such controlled substances in any one week in the previous year. These limitations shall not apply to Schedule V controlled substances which Federal law prohibits from being dispensed without a prescription.

(d) The Department of Registration and Education by rule may exempt controlled substances from the necessity of being dispensed by prescription.

(e) Every practitioner shall keep a record of controlled substances received by him and a record of all such controlled substances administered, dispensed or professionally used by him otherwise than by prescription. It shall, however, be a sufficient compliance with this paragraph if any such person using small quantities of solutions or other preparations of such controlled substances shall keep a record of the quantity, character and potency of such solutions or other preparations purchased or made by him, and of the dates when purchased or made by him, without keeping a record of the amount of such solution or other preparation administered or dispensed to individual patients.

(f) Whenever a manufacturer distributes a controlled substance in a package prepared by him, and whenever a wholesale distributor distributes a controlled substance in a package prepared by him or the manufacturer, he shall securely affix to each package in which that substance is contained a label showing in legible English the name and address of the manufacturer, the distributor and the quantity, kind and form of controlled substance contained therein. No person except a pharmacist and only for the purposes of filling a prescription under this Act, shall alter, deface or remove any label so affixed.

(g) Whenever a practitioner dispenses any controlled substance, he shall affix to the container in which such substance is sold or dispensed, a label showing his own name, address and registry number, the name and address of the ultimate user; if the user is an animal, the name and address of the owner of the animal and the species of the animal; the name and registry number of the practitioner by whom the written or oral prescription was issued; and such directions as may be stated on the written prescription. No person shall alter, deface or remove any label so affixed.

(h) A person to whom or for whose use any controlled substance has been prescribed or dispensed by a practitioner, or other persons authorized under this Act, and the owner of any animal for which such substance has been prescribed or dispensed by a veterinarian, may lawfully possess such substance only in the container in which it was delivered to him by the person dispensing such substance.

Section 313. Controlled substances which are lawfully administered in hospitals or institutions licensed under the "Hospital Licensing Act" shall be exempt from the requirements of Section 312 except that the prescription for the controlled substance shall be in writing on the patient's record, signed by the prescriber, dated, and shall state the name, and quantity of controlled substances ordered and the quantity actually administered. The records of such prescriptions shall be maintained for two years and shall be available for inspection by officials and employees of the Department of Law Enforcement, and the Department of Registration and Education.

Section 314. Except when a practitioner shall dispense on behalf of a charitable organization as defined in Section 501 (c) of the Federal "Internal Revenue Act", and then in conformance with other provisions of State and Federal laws relating to the dispensing of controlled substances, no practitioner shall dispense a controlled substance by use of the United States mails or other commercial carriers.

Section 315. No controlled substance shall be advertised to the public by name.

ARTICLE IV

Section 401. Except as authorized by this Act, it is unlawful for any person knowingly to manufacture or deliver, or possess with intent to manufacture, or deliver, a controlled substance. Any person who violates this Section with respect to:

(a) the following controlled substances and amounts, notwithstanding any of the provisions of subsections (b), (c), (d), or (e) to the contrary, is guilty of an offense and shall upon conviction be imprisoned in the penitentiary for not less than 10 years nor more than life, and fined not more than $200,000:

(1) 30 grams or more of any substance containing heroin;

(2) 30 grams or more of any substance containing cocaine;

(3) 30 grams or more of any substance containing morphine;

(4) 1,000 grams or more of any substance containing peyote;

(5) 200 grams or more of any substance containing a derivative of barbituric acid or any of the salts of a derivative of barbituric acid;

(6) 200 grams or more of any substace containing amphetamine or methamphetamine or any salt of an optical isomer of amphetamine or methamphetamine;

(7) 300 grams or more of any substance containing any of the following substances, their salts, isomers and salts of isomers:

(i) diethyltryptamine (DET); dimethyltryptamine (DMT); psilocybin (psilocibin, O-phosphoryl-4-hydroxy-N, N-dimethyltryptamine); or psilocyn (psilocin, 4-hydroxy-N, N-dimethyltryptamine);

(ii) N-ethyl-3-piperidyl benzilate (JB 318); N-methyl 3-piperidyl benzilate (JB 336);

(iii) 1-(1-Phenylcyclohexl) - piperidine (Phencyclidine, PCP);

(iv) 3, 4, 5-trimethoxyamphetamine (TMA); 4-methyl, 2, 5-dimethoxyamphetamine (DOM, STP); 3, 4-methylenedioxyamphetamine (alpha-methyl, 3, 4-methylenedioxyphenethylamine, methylenedioxyamphetamine, MDA); or 3-methoxy-4, 5-methylenedioxyamphetamine (MMDA);

(v) 3, 4, 5-trimethoxyphenethylamine (mescaline) other than peyote;

(8) 30 grams or more of any substance containing lysergic acid diethylamide (LSD).

(b) any other amount of a controlled substance classified in Schedules I or II which is a narcotic drug is guilty of an offense and upon conviction shall be imprisoned in the penitentiary from one to 20 years, and fined not more than $25,000;

(c) any other amount of a controlled substance classified in Schedule I or II which is not a narcotic drug is guilty of an offense and upon conviction shall be imprisoned in the penitentiary from one to 10 years, and fined not more than $20,000;

(d) any other amount of a controlled substance classified in Schedule III is guilty of an offense and upon conviction shall be imprisoned in the penitentiary from one to 8 years, and fined not more than $15,000;

(e) any other amount of a controlled substance classified in Schedule IV is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 3 years, and fined not more than $10,000;

(f) any other amount of a controlled substance classified in Schedule V is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 3 years, and fined not more than $5,000.

Section 402. Except as otherwise authorized by this Act, it is unlawful for any person knowingly to possess a controlled substance. Any person who violates this Section with respect to:

(a) the following controlled substances and amounts, notwithstanding any of the provisions of subsections (b) or (c) to the contrary, is guilty of an offense and shall be imprisoned in the penitentiary for not less than 3 years nor more than life, and fined not more than $100,000:

(1) 30 grams or more of any substance containing heroin;

(2) 30 grams or more of any substance containing cocaine;

(3) 30 grams or more of any substance containing morphine;

(4) 1,000 grams or more of any substance containing peyote;

(5) 200 grams or more of any substance containing a derivative of barbituric acid or any of the salts of a derivative of barbituric acid;

(6) 200 grams or more of any substance containing amphetamine or methamphetamine or any salt of an optical isomer of amphetamine or methaphetamine;

(7) 300 grams or more of any substance containing any of the following substances, their salts, isomers and salts of isomers:

(i) diethyltryptamine (DET); dimethyltryptamine (DMT); psilocybin (psilocibin, O-phosphoryl-4-hydroxy-N, N-dimethyltryptamine); or

(ii) N-ethyl-3-piperidyl benzilate (JB 318); or N-methyl-3-piperidyl benzilate (JB 336);

(iii) 1-(1-Phenylcyclohexl)-piperidine (Phencyclidine, PCP);

(iv) 3, 4, 5-trimethoxyamphetamine (TMA); 4-methyl, 2, 5-dimethoxyamphetamine (DOM, STP); 3, 4-methylenedioxyamphetamine (alpha-methyl, 3, 4-methylenedioxyphenethylamine, methylenedioxyamphetamine, MDA); or 3-methoxy-4, 5-methylenedioxyamphetamine (MMDA);

(v) 3, 4, 5-trimethoxyphenethylamine (mescaline) other than peyote;

(8) 30 grams or more of any substance containing lysergic acid diethylamide (LSD).

(b) any other amount of a controlled substance is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 8 years, and fined not more than $15,000.

Section 403. Except as authorized by this Act, it is unlawful for any person knowingly to manufacture or deliver a counterfeit substance. Any person who violates this section with respect to:

(a) a counterfeit substance classified in Schedules I or II, which is a narcotic drug, is guilty of an offense and upon conviction shall be imprisoned in the penitentiary from one to 12 years and fined not more than $25,000;

(b) any other counterfeit substance classified in Schedules I or II, is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or in the penitentiary from 1 to 8 years, and fined not more than $20,000;

(c) a counterfeit substance classified in Schedule III, is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or in the penitentiary from 1 to 5 years and fined not more than $15,000;

(d) a counterfeit substance classified in Schedule IV, is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or in the penitentiary from 1 to 3 years, and fined not more than $10,000;

(e) a counterfeit substance classified in Schedule V, is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year, and fined not more than $5,000.

Section 404. Except as authorized by this Act, it is unlawful for any person knowingly to deliver or possess with intent to deliver any substance which he represents to be a controlled substance. Any person who violates this Section is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 10 years, and fined not more than $15,000.

Section 405. (a) Any person who engages in a calculated criminal drug conspiracy, as defined in subsection (b), is guilty of an offense and upon conviction shall be imprisoned in the penitentiary for not less than 10 years nor more than life, and fined not more than $200,000, and shall be subject to the forfeitures prescribed in subsection (c).

(b) For purposes of this section, a person engages in a calculated criminal drug conspiracy when:

(1) he violates any of the provisions of subsections (a) or (b) of Section 401 or subsection (a) of Section 402; and

(2) such violation is a part of a conspiracy undertaken or carried on with two or more other persons; and

(3) he obtains anything of value greater than $500 from, or oganizes, directs or finances such violation or conspiracy.

(c) Any person who is convicted under this section of engaging in a calculated criminal drug conspiracy shall forfeit to the State of Illinois:

(1) the receipts obtained by him in such conspiracy; and

(2) any of his interests in, claims against, receipts from, or property or rights of any kind affording a source of influence over, such conspiracy.

(d) Any court shall have jurisdiction to enter such injunctions, restraining orders, directions or prohibitions, or to take such other actions, including the acceptance of satisfactory performance bonds, in connection with any property, claim, receipt, right or other interest subject to forfeiture under this section, as it deems proper.

Section 406. (a) It is unlawful for any person:

(1) who is subject to Article III knowingly to distribute or dispense a controlled substance in violation of Sections 308 through 314 of this Act; or

(2) who is a registrant, to manufacture a controlled substance not authorized by his registration, or to distribute or dispense a controlled substance not authorized by his registration to another registrant or other authorized person; or

(3) to refuse or fail to make, keep or furnish any record, notification, order form, statement, invoice or information required under this Act; or

(4) to refuse an entry into any premises for any inspection authorized by this Act; or

(5) knowingly to keep or maintain any store, shop, warehouse, dwelling, building, vehicle, boat, aircraft, or other structure or place, which is resorted to by a person unlawfully possessing controlled substances, or which is used for possessing, manufacturing, dispensing or distributing controlled substances in violation of this Act.

Any person who violates this subsection (a) is guilty

of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 3 years, and fined not more than $10,000.

(b) It is unlawful for any person knowingly:

(1) to distribute, as a registrant, a controlled substance classified in Schedule I or II, except pursuant to an order form as required by Section 307 of this Act; or

(2) to use, in the course of the manufacture or distribution of a controlled substance, a registration number which is fictitious, revoked, suspended, or issued to another person; or

(3) to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge; or

(4) to furnish false or fradulent material information in, or omit any material information from, any application, report or other document required to be kept or filed under this Act, or any record required to be kept by this Act; or

(5) to make, distribute or possess any punch, die, plate, stone or other thing designed to print, imprint or reproduce the trademark, trade name or other identifying mark, imprint or device of another, or any likeness of any of the foregoing, upon any controlled substance or container or labeling thereof so as to render the drug a counterfeit substance; or

(6) to possess without authorization, official blank prescription forms or counterfeit prescription forms; or

(7) to issue a prescription or fill any prescription for a controlled substance other than on the appropiate lawful prescription form. However, in the case of any epidemic or sudden or unforeseen accident or calamity, the prescriber may issue a prescription on a form other than the official prescription form issued by the Department, where failure to issue such a prescription might result in loss of life or intense suffering, but such prescription shall have endorsed thereon, by the prescriber, a statement concerning the accident, calamity or circumstance constituting the emergency, the cause of which the unofficial blank was used.

Any person who violates this subsection (b) is guilty of an offense and upon conviction shall be imprisoned in a penal institution other than the penitentiary for not more than one year or in the penitentiary from one to 3 years, and fined not more than $30,000.

Section 407. Any person 18 years of age or over who violates any subsection of Section 401 by delivering a controlled substance to a person under 18 years of age who is at least two years his junior is punishable by a sentence up to twice the maximum otherwise authorized by the pertinent subsection of Section 401;

Section 408. (a) Any person convicted of a second or subsequent offense under this Act may be imprisoned for a term up to twice the term otherwise authorized, fined an amount up to twice that otherwise authorized, or both.

(b) For purposes of this Section, an offense is considered a second or subsequent offense, if, prior to his conviction of the offense, the offender has at any time been convicted under this Act or under any law of the United States or of any State relating to controlled substances.

Section 409. A conviction or acquittal, under the laws of the United States or of any State relating to controlled substances, for the same act is a bar to prosecution in this State.

Section 410. Whenever any person who has not previously been convicted under any law of the United States or of any State relating to controlled substances, pleads guilty to or is found guilty of possession of a controlled substance under Section 402 (b), the court, without entering a judgment of conviction and with the consent of the accused, may defer further proceedings and place him on probation upon terms and conditions which may include treatment or rehabilitation approved by the Department of Mental Health. Upon violation of a term or condition, the court may enter a judgment of conviction and proceed as otherwise provided. Upon fulfillment of the terms and conditions, the court shall discharge the person and dismiss the proceedings against him. Discharge and dismissal under this Section is not a conviction for purposes of this Act or for purposes of disqualifications or disabilities imposed by law upon conviction of a crime. There may be only one discharge and dismissal under this Section with respect to any person.

Section 411. In determining the appropriate sentence for any conviction under this Act, the sentencing court may consider the following as indicative of the type of offenses which the legislature deems most damaging to the peace and welfare of the citizens of Illinois and which warrants the most severe penalties:

(1) the unlawful delivery of the most highly toxic controlled substances, as reflected by their inclusion in Schedule I or II of this Act;

(2) offenses involving unusually large quantities of controlled substances, as measured by their wholesale value at the time of the offense;

(3) the unlawful delivery of controlled substances by a non-user to a user of controlled substances;

(4) non-possessory offenses by persons who have no other visible means of support;

(5) offenses involving the large-scale manufacture of controlled substances;

(6) offenses which indicate any immediate involvement whatsoever with organized crime in terms of the controlled substance's manufacture, importation, or volume distribution;

(7) the manufacture for, or the delivery of controlled substances to persons 3 years or more junior to the person (s) convicted under this Act.

Nothing in this section shall be construed as limiting in any way the discretion of the court to impose any sentence authorized by this Act.

Section 412. Any penalty imposed for any violation of this Act is in addition to, and not in lieu of, any civil or administrative penalty or sanction otherwise authorized by this Act or any other law.

ARTICLE V

Section 501. It is hereby made the duty of the Department, its agents, officers, investigators, and of all peace officers of this State to enforce all provisions of this Act, except those specifically delegated, and to cooperate with all agencies charged with the enforcement of the laws of the United States, or of any State, relating to controlled substances. Any agent, officer, investigator or peace officer designated by the Director may (a) execute and serve administrative inspection warrants, subpoenas, and summonses under the authority of this State; (b) makes seizures of property pursuant to the provisions of this Act; and (c) perform such other law enforcement duties as the Director may designate. It is hereby made the duty of all State's Attorneys to prosecute violations of this Act and institute legal proceedings as authorized under this Act.

Section 502. (a) Issuance and execution of administrative inspection warrants shall be as follows:

(1) a judge of a circuit court, within his jurisdiction, and upon proper oath or affirmation showing probable cause, may issue warrants for the purpose of conducting administrative inspections authorized by this Act or rules

hereunder, and seizures of property appropriate to the inspections. For purposes of the issuance of administrative inspection warrants, probable cause exists upon showing a valid public interest in the effective enforcement of this Act or rules hereunder, sufficient to justify administrative inspection of the controlled premises, as defined in subsection (b), specified in the application for the warrant.

(2) an inspection warrant shall issue only upon an affidavit of any person having knowledge of the facts alleged, sworn to before the circuit judge and establishing the grounds for issuing the inspection warrant. If the circuit judge is satisfied that there is probable cause to believe that grounds for issuance of an inspection warrant exist, he shall issue an inspection warrant identifying the controlled premises to be inspected, the purpose of the inspection, and, if appropriate, the type of property to be inspected or seized, if any.

The inspection warrant shall:

(i) state the ground for its issuance and the name of each person whose affidavit has been taken in support thereof;

(ii) be directed to a person authorized by Section 501 to execute it;

(iii) command the person to whom it is directed to inspect the controlled premises identified for the purpose specified and, if appropriate, direct the seizure of the property specified;

(iv) identify the item or types of property to be seized, if any;

(v) direct that it be served at any time of the day or night and designate the circuit court judge to whom it shall be returned.

(3) an inspection warrant issued pursuant to this Section must be executed and returned within 10 days of its date of issuance unless, upon a showing of a need for additional time, the court which issued the inspection warrant orders otherwise. If property is seized pursuant to an inspection warrant, a copy of the inventory of such seized property shall be given to the person from whom or from whose controlled premises the property is taken. If no person is available, the inspection warrant and a copy of the inventory shall be left at such controlled premises. The inventory shall be made under oath by the person executing the warrant.

(4) an inspection warrant shall be returnable before the judge of the circuit court who issued the inspection warrant or any judge named in the inspection warrant or before any court of competent jurisdiction. The judge before whom the return is made shall attach to the inspection warrant a copy of the return and all papers returnable in connection therewith and file them with the clerk of the circuit court in which the inspection warrant was executed.

(5) no warrant shall be quashed nor evidence suppresed because of technical irregularities not affecting the substantial rights of the person responsible for the controlled premises.

(b) The Director may make inspections of controlled premises in accordance with the following provisions:

(1) For purposes of this Section only, "controlled premises" means:

(i) places where persons registered or exempted from registration requirements under this Act keep records required under this Act; and

(ii) places, including but not limited to, areas, buildings, premises, factories, warehouses, establishments and conveyances in which persons registered or exempted from registration requirements under this Act are permitted to possess, manufacture, distribute, dispense, administer, or otherwise dispose of any controlled substance.

(2) When authorized by an inspection warrant issued pursuant to this Act, any agent designated by the Director or any peace officer, upon presenting the inspection warrant to the person designated in the inspection warrant or any other person on the controlled premises, may enter controlled premises for the purpose of conducting the inspection.

(3) When authorized by an inspection warrant any agent designated by the Director may execute the inspection warrant in accordance with its terms.

(4) This section does not prevent the inspection without a warrant of books and records pursuant to an administrative subpoena issued in accordance with "The Civil Administrative Code of Illinois," nor does it prevent entries and administrative inspections, including seizures of property, without a warrant:

(i) if the person in charge of the controlled premises consents; or

(ii) in situations presenting imminent danger to health or safety; or

(iii) in situations involving inspection of conveyances if there is reasonable cause to believe that the mobility of the conveyance makes it impracticable to obtain a warrant; or

(iv) in any other exceptional or emergency circumstance where time or opportunity to apply for a warrant is lacking.

(5) An inspection warrant authorized by this Section shall not extend to financial data, sales data, other than shipment data, or pricing data unless the person in charge of the controlled premises consents in writing, provided, however, that records required to be kept under this Act are not included in such financial data, sales data or pricing data.

Section 503. In addition to any other remedies the Director is authorized to apply to any circuit court for, and such circuit court shall have jurisdiction upon hearing and for cause shown to grant a temporary or permanent injunction, without bond, restraining any person from violating any provision of this Act whether or not there exists an adequate remedy at law.

Section 504. (a) The Director shall cooperate with Federal and other State agencies in discharging his responsibilities concerning traffic in controlled substances and in suppressing the misuse and abuse of controlled substances. To this end he may:

(1) arrange for the exchange of information among governmental officials concerning the use, misuse and abuse of controlled substances;

(2) coordinate and cooperate in training programs concerning controlled substance law enforcement at local and State levels;

(3) cooperate with the Bureau; and

(4) conduct programs of eradication aimed at destorying wild illicit growth of plant species from which controlled substances may be extracted.

(b) Results, information, and evidence received from the Bureau relating to the regulatory functions of this Act, including results of inspections conducted by it may be relied and acted upon by the Director in the exercise of his regulatory functions under this Act.

Section 505. (a) The following are subject to forfeiture:

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

(2) all raw materials, products and equipment of any kind which are manufactured, distributed, dispensed, administered or possessed in connection with any controlled substance in violation of this Act;

(3) all conveyances, including aircraft, vehicles or vessels, which are used, or intended for use, to transport,

or in any manner to facilitate the transportation, for the purpose of delivery of property described in paragraph (1) or (2), but:

(i) no conveyance used by any person as a common carrier in the transaction of business as a common carrier is subject to forfeiture under this Section unless it appears that the owner or other person in charge of the conveyance is a consenting party or privy to a violation of this Act;

(ii) no conveyance is subject to forfeiture under this Section by reason of any act or omission which the owner proves to have been committed or omitted without his knowledge or consent;

(iii) a forfeiture of a conveyance encumbered by a bona fide security interest is subject to the interest of the secured party if he neither had knowledge of nor consented to the act or omission;

(4) all money, things of value, books, records, and research products and materials including formulas, microfilm, tapes, and data which are used, or intended for use, in violation of this Act.

(b) Property subject to forfeiture under this Act may be seized by the Director or any peace officer upon process issued by any court having jurisdiction over the property. Seizure by the Director or any peace officer without process may be made:

(1) If the seizure is incident to inspection under an administrative inspection warrant;

(2) If the property subject to seizure has been the subject of a prior judgment in favor of the State in a criminal injunction or forfeiture proceeding based upon this Act;

(3) If there is probable cause to believe that the property is directly or indirectly dangerous to health or safety; or

(4) in accordance with the Code of Criminal Procedure of 1963, as amended.

(c) In the event of seizure pursuant to subsection (b), proceedings under subsection (d) shall be instituted promptly.

(d) Property taken or detained under this Section shall not be subject to replevin, but is deemed to be in the custody of the Director subject only to the order and decrees of the circuit court having jurisdiction over the forfeiture proceedings. When property is seized under this Act, the Director may:

(1) place the property under seal; or

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

(3) require the sheriff of the county in which the seizure occurs to take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(e) If the Department of Registration and Education suspends or revokes a registration, all controlled substances owned or possessed by the registrant at the time of suspension or the effective date of the revocation order may be placed under seal. No disposition may be made of substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application therefore, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court. Upon a revocation rule becoming final, all controlled substances may be forfeited to the Department.

(f) When property is forfeited under this Act the Director may:

(1) retain it for official use; or

(2) sell that which is not required to be destroyed by law and which is not harmful to the public. The proceeds shall be used for payment of all proper expenses of the proceedings for forfeiture and sale, including expenses of seizure, maintenance of custody, advertising and court costs and the balance, if any, shall be paid to the State of Illinois; or

(3) require the sheriff of the county which the forfeiture occurs to take custody of the property and remove it for disposition in accordance with law; or

(4) forward it to the Bureau for disposition.

(g) Species of plants from which controlled substances in Schedules I and II may be derived which have been planted or cultivated in violation of this Act, or of which the owners or cultivators are unknown, or which are wild growths, may be seized and summarily forfeited to the State. The failure, upon demand by the Director or any peace officer, of the person in occupancy or in control of land or premises upon which the species of plants are growing or being stored, to produce registration, or proof that he is the holder thereof, constitutes authority for the seizure and forfeiture of the plants.

Section 506. It is not necessary for the State to negate any exemption or exception in this Act in any complaint, information, indictment or other pleading or in any trial, hearing, or other proceeding under this Act. The burden of proof of any exemption or exception is upon the person claiming it.

Section 507. All rulings, final determinations, findings, and conclusions of the Department of Law Enforcement, the Department of Registration and Education and the Department of Mental Health under this Act are final and conclusive decisions of the matters involved. Any person aggrieved by the decision may obtain review of the decision pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, as amended and the rules adopted pursuant thereto.

Section 508. The Department of Mental Hetalth shall encourage research on controlled substances. In connection with the research, and in furtherance of the purposes of this Act, the Department of Mental Health may:

(1) establish methods to assess accurately the effect of controlled substances and identify and characterize those with potential for abuse;

(2) make studies and undertake programs of research to:

(i) develop new or improved approaches, techniques, systems, equipment and devices to strengthen the enforcement of this Act;

(ii) determine patterns of use, misuse, and abuse of controlled substances and their social effects; and

(iii) improve methods for preventing, predicting, understanding and dealing with the use, misuse and abuse of controlled substances; and

(3) enter into contracts with public agencies, educational institutions, and private organizations or individuals for the purpose of conducting research, demonstrations, or special projects which relate to the use, misuse and abuse of controlled substances.

(b) Persons authorized to engage in research may be authorized by the Department of Mental Health to protect the privacy of individuals who are the subjects of such research by withholding from all persons not connected with the conduct of the research the names and other identifying characteristics of such individuals. Persons who are given this authorization shall not be compelled in any civil, criminal, administrative, legislative or other proceedings to identify the individuals who are the subjects of research for which the authorization was granted, except to the extent necessary to permit the Department of Mental Health to determine whether the research is being conducted in accordance with the authorization.

(c) The Department of Mental Health, with the approval of the Department of Law Enforcement, may authorize

the possession and dispensing of controlled substances by persons engaged in research, upon such terms and conditions as may be consistent with the public health and safety. The Department of Mental Health may also approve research and treatment programs involving the administration of Methadone. The use of Methadone, or any similar controlled substance by any person is prohibited in this State except as approved and authorized by the Department of Mental Health in accordance with its rules and regulations. To the extent of the applicable authorization, persons are exempt from prosecution in this State for possession, manufacture or delivery of controlled substances.

(d) Practitioners registered under Federal law to conduct research with Schedule I substances may conduct research with Schedule I substances within this State upon furnishing evidence of that Federal registration.

Section 509. Whenever any court in this State grants probation to any person that the court has reason to believe is or has been an addict or unlawful possessor of controlled substances, the court shall require, as a condition of probation, that the probationer submit to periodic tests by the Department of Corrections to determine by means of appropriate chemical detection tests whether the probationer is using controlled substances. The court may require as a condition of probation that the probationer enter an approved treatment program, if the court determines that the probationer is addicted to a controlled substance. Whenever the Parole and Pardon Boards grants parole to a person whom the Board has reason to believe has been an unlawful possessor or addict of controlled substances, the Board shall require as a condition of parole that the parolee submit to appropriate periodic chemical tests by the Department of Corrections to determine whether the parolee is using controlled substances.

ARTICLE VI

Section 601. Prosecution for any violation of law occurring prior to the effective date of this Act is not affected or abated by this Act. If the offense being prosecuted would be a violation of this Act, and has not reached the sentencing stage or final adjudication, then for purposes of penalty the penalties under this Act apply if they are less than under the prior law upon which the prosecution was commenced.

Section 602. If any provision of this Act or the application thereof to any person or circumstance is invalid, such invalidation shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

Section 603. The following Acts and parts of Acts are repealed:

(a) The "Uniform Narcotic Drug Act," approved July 11, 1957, as amended.

(b) The "Drug Abuse Control Act," approved August 17, 1967, as amended.

(c) "An Act to amend Sections 2—15, 41 (a) and 43 of, and to add Sections 43.1, 43.2, 43.3, 43.4. 43.5, 43.6 and 43.7 to the 'Uniform Drug, Device and Cosmetic Act', approved July 9, 1959, as amended," approved August 11, 1967, as amended.

(d) "An Act to amend Section 46 of the 'Uniform Drug, Device and Cosmetic Act', approved July 9, 1959, as amended," approved August 18, 1967, as amended.

ILLINOIS CONTROLLED SUBSTANCES ACT

*Penalty Structure

Illegal Act	Drug Involved	**Penalty
Calculated criminal drug conspiracy (Sec. 405)	Any drugs involving more than $500 value	10 years to life
Manufacture or deliver or possession with intent to manufacture or deliver (Sec. 401)	1. Specified large quantities of specific substances	10 years to life
	2. Schedule I or II narcotic substances	1 - 20 years
	3. Schedule I or II, any other substances	1 - 10 years
	4. Schedule III controlled substances	1 - 8 years
	5. Schedule IV and V controlled substances	Not more than 1 year or 1 - 3 years
Possession of controlled substances (Sec. 402)	1. Specified large quantities of specific substances	3 years to life.
	2. All other controlled substances	Not more than 1 year or 1 - 8 years. First offense, possible discharge after fulfilling of probation. (Sec. 410)
Manufacture or deliver a counterfeit substance (Sec. 403)	1. Schedule I or II narcotic substances	1 - 12 years
	2. Schedule I or II, any other substances	Not more than 1 year or 1 - 8 years
	3. Schedule III controlled substances	Not more than 1 year or 1 - 5 years
	4. Schedule IV and V controlled substances	Not more than 1 year or 1 - 3 years
Falsely representing any substance to be a controlled substance (Sec. 404)	Any non-controlled substance	Not more than 1 year or 1 - 10 years
Distribute controlled substances in violation of the prescription requirements, failure to keep proper records, obtain prescription blanks or use false identifications, registrations or counterfeit labels (Sec. 406)	Any controlled substance	Not more than 1 year or 1 - 3 years
Delivery of a controlled substance to a person under 18 years and 2 years his junior (Sec. 407)	Any controlled substance	Twice the maximum otherwise authorized penalty

* This chart provides general guidelines and should be checked against the **Illinois Controlled Substances Act** at all times.

** There are also fines assessed for all violations, but they are not listed on the chart.

APPENDIX 3

The Cannabis Control Act

Effective August 16, 1971

AN ACT to establish a regulatory system for the production, distribution and possession of marihuana.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. The General Assembly recognizes that (1) the current state of scientific and medical knowledge concerning the effects of cannabis makes it necessary to acknowledge the physical, psychological and sociological damage which is incumbent upon its use; and (2) the use of cannabis occupies the unusual position of being widely used and pervasive among the citizens of Illinois despite its harmful effects; and (3) previous legislation enacted to control or forbid the use of cannabis has often unnecessarily and unrealistically drawn a large segment of our population within the criminal justice system without succeeding in deterring the expansion of cannabis use. It is, therefore, the intent of the General Assembly, in the interest of the health and welfare of the citizens of Illinois, to establish a reasonable penalty system which is responsive to the current state of knowledge concerning cannabis and which directs the greatest efforts of law enforcement agencies toward the commercial traffickers and large-scale purveyors of cannabis. To this end, this Act provides wide latitude in the sentencing discretion of the courts and establishes penalties in a sharply rising progression based on the amount of substances containing cannabis involved in each case.

Section 2. This Act shall be known and may be cited as the "Cannabis Control Act".

Section 3. As used in this Act, unless the context otherwise requires:

(a) "Cannabis" includes marihuana, hashish and other substances which are identified as including any parts of the plant Cannabis Sativa, whether growing or not; the seeds thereof, the resin extracted from any part of such plant; and any compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or resin, including tetrahydrocannabinol (THC) and all other cannabinol derivatives, including its naturally occurring or synthetically produced ingredients, whether produced directly or indirectly by extraction, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis; but shall not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil or cake, or the sterilized seed of such plant which is incapable of germination.

(b) "Casual delivery" means the delivery of not more than 10 grams of any substance containing cannabis without consideration.

(c) "Deliver" or "delivery" means the actual, constructive or attempted transfer of possession of cannabis, with or without consideration, whether or not there is an agency relationship.

(d) "Department of Law Enforcement" means the Department of Law Enforcement of the State of Illinois or its successor agency.

(e) "Department of Mental Health" means the Department of Mental Health of the State of Illinois or its successor agency.

(f) "Director" means the Director of the Department of Law Enforcement or his designated agent.

(g) "Local authorities" means a duly organized State, county, or muncipal peace unit or police force.

(h) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of cannabis, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of cannabis or labeling of its container, except that this term does not include the preparation, compounding, packaging, or labeling of cannabis as an incident to lawful research, teaching, or chemical analysis and not for sale.

(i) "Person" means any individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other entity.

(j) "Produce" or "production" means planting, cultivating, tending or harvesting.

(k) "State" includes the State of Illinois and any state, district, commonwealth, territory, insular possession thereof, and any area subject to the legal authority of the United States of America.

(l) "Subsequent offense" means an offense under this Act, the offender of which, prior to his conviction of the offense, has at any time been convicted under this Act or under any laws of the United States or of any state relating to cannabis, or any controlled substance as defined in the Illinois Controlled Substances Act.

Section 4. It is unlawful for any person knowingly to possess cannabis. Any person who violates this section with respect to:

(a) not more than 2.5 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 90 days;

(b) more than 2.5 grams but not more than 10 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 180 days;

(c) more than 10 grams but not more than 30 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year; provided, that if any offense under this subsection (c) is a subsequent offense, the offender shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or the penitentiary from 1 to 2 years;

(d) more than 30 grams but not more than 500 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in the penitentiary from 1 to 3 years; provided that if any offense under this subsection (d) is a subsequent offense, the offender shall be imprisoned in the penitentiary from 2 to 6 years;

(e) more than 500 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in the penitentiary from 1 to 5 years; provided, that if any offense under this subsection (e) is a subsequent offense, the offender shall be imprisoned in the penitentiary from 2 to 7 years.

Section 5. It is unlawful for any person knowingly to manufacture, deliver, or possess with intent to deliver, or manufacture, cannabis. Any person who violates this section with respect to:

(a) not more than 2.5 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 180 days;

(b) more than 2.5 grams but not more than 10 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or in the penitentiary from 1 to 2 years;

(c) more than 10 grams but not more than 30 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year or in the penitentiary from 1 to 3 years; provided, that if any offense under this subsection (c) is a subsequent offense, the offender shall be imprisoned in the penitentiary from 1 to 4 years;

(d) more than 30 grams but not more than 500 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in the penitentiary from 1 to 4 years; provided, that if any offense under this subsection (d) is a subsequent offense, the offender shall be imprisoned in the penitentiary from 2 to 8 years;

(e) more than 500 grams of any substance containing cannabis is guilty of an offense and shall be imprisoned in the penitentiary from 1 to 7 years; provided, that if any offense under this subsection (e) is a subsequent offense, the offender shall be imprisoned in the penitentiary from 2 to 10 years.

Section 6. Any delivery of cannabis which is a casual delivery shall be treated in all respects as possession of cannabis for purposes of penalties.

Section 7. (a) Any person who is at least 18 years of age who violates Section 5 of this Act by delivering cannabis to a person under 18 years of age who is at least 3 years his junior is punishable by a sentence up to twice the maximum otherwise authorized by Section 5.

(b) Any person under 18 years of age who violates Section 4 or 5 of this Act may be treated by the court in accordance with the Juvenile Court Act.

Section 8. Any person who knowingly produces the cannabis sativa plant is guilty of an offense and shall be imprisoned in a penal institution other than the penitentiary for not more than 1 year, or fined not more than $1,500, or both.

Section 9. (a) Any person who engages in a calculated criminal cannabis conspiracy, as defined in subsection (b), is guilty of an offense and upon conviction shall be imprisoned in the penitentiary from 3 to 10 years, and fined not more than $200,000 and shall be subject to the forfeitures prescribed in subsection (c), except that, if any person engages in such offense after one or more prior convictions under this section, section 4 (d), section 5 (d), or any law of the United States or of any State relating to cannabis, or controlled substances as defined in the Illinois Controlled Substances Act, in addition to the fine and forfeiture authorized above, he shall be imprisoned in the penitentiary from 5 to 20 years.

(b) For purposes of this section, a person engages in a calculated criminal cannabis conspiracy when:

(1) he violates subsection 4 (d) or 5 (d) of this Act; and

(2) such violation is a part of a conspiracy undertaken or carried on with two or more other persons; and

(3) he obtains anything of value greater than $500 from, or organizes, directs or finances such violation or conspiracy.

(c) Any person who is convicted under this section of engaging in a calculated criminal cannabis conspiracy shall forfeit to the State of Illinois:

(1) the receipts obtained by him in such conspiracy; and

(2) any of his interests in, claims against, receipts from, or property or rights of any kind affording a source of influence over, such conspiracy.

(d) Any court shall have jurisdiction to enter such injunctions, restraining orders, directions, or prohibitions, or to take such other actions, including the acceptance of satisfactory performance bonds, in connection with any property, claim, receipt, right or other interest subject to forfeiture under this section, as it deems proper.

Section 10. Whenever any person who has not previously been convicted of any offense under this Act or any law of the United States or of any State relating to cannibis, or controlled substances as defined in the Illinois Controlled Substances Act, pleads guilty to or is found guilty of violating Sections 4 (a), 5 (a), or 8 of this Act, the court may, without entering a judgement of guilt and with the consent of such person, defer further proceedings and place him on probation upon reasonable terms and conditions as it may require. Upon violation of a term or condition, the court may enter an adjudication of guilt and proceed as otherwise provided. Upon fulfillment of the terms and conditions, the court shall discharge such person and dismiss the proceedings against him. Discharge and dismissal under this Section shall be without court adjudication of guilt and shall not be deemed a conviction for purposes of disqualification or disabilities imposed by law upon conviction of a crime (including the additional penalty imposed for subsequent offenses under Section 4 (c), 4 (d), 5 (c) or 5 (d) of this Act). Discharge and dismissal under this Section may occur only once with respect to any person.

Section 11. (a) The Department of Mental Health, with the approval of the Department of Law Enforcement, may authorize the possession, production, manufacture and delivery of substances containing cannabis by persons engaged in research, upon such terms and conditions as may be consistent with the public health and safety. To the extent of the applicable authorization, persons are exempt from prosecution in this State for possession, production, manufacture or delivery of cannabis.

(b) Persons registered under Federal law to conduct research with cannabis may conduct research with cannabis within this State upon furnishing evidence to the Department of Law Enforcement of that Federal registration.

(c) Persons authorized to engage in research may be authorized by the Department of Mental Health to protect the privacy of individuals who are the subjects of such research by withholding from all persons not connected with the conduct of the research the names and other identifying characteristics of such individuals. Persons who are given this authorization shall not be compelled in any civil, criminal, administrative, legislative or other proceeding to identify the individuals who are the subjects of research for which the authorization was granted, except to the extent necessary to permit the Department of Mental Health to determine whether the research is being conducted in accordance with the authorization.

Section 12. (a) The following are subject to forfeiture:

(1) all substances containing cannabis which have been produced, manufactured, delivered, or possessed in violation of this Act;

(2) all raw materials, products and equipment of any kind which are produced, delivered, or possessed in connection with any substance containing cannabis in violation of this Act;

(3) all conveyances, including aircraft, vehicles or vessels, which are used, or intended for use, to transport, or in any manner to facilitate the transportation, for the purpose of delivery of property described in paragraph (1) or (2), but:

(i) no conveyance used by any person as a common carrier in the transaction of business as a common carrier is subject to forfeiture under this Section unless it appears that the owner or other person in charge of the conveyance is a consenting party or privy to a violation of this Act;

(ii) no conveyance is subject to forfeiture under this Section by reason of any act or omission which the owner proves to have been committed or omitted without his knowledge or consent;

(iii) a forfeiture of a conveyance encumbered by a bona fide security interest is subject to the interest of the secured party if he neither had knowledge of nor consented to the act or omission;

(4) all moneys, things of value, books, records, and research products and materials including formulas, microfilm, tapes, and data which are used, or intended for use, in violation of this Act.

(b) Property subject to forfeiture under this Act may be seized by the Director or any peace officer upon process issued by any court having jurisdiction over the property. Seizure by the Director or any peace officer without process may be made:

(1) If the property subject to seizure has been the subject of a prior judgment in favor of the State in a criminal, injunction or forfeiture proceeding based upon this Act;

(2) If there is probable cause to believe that the property is directly or indirectly dangerous to health or safety; or

(3) In accordance with the Code of Criminal Procedure of 1963, as amended.

(c) In the event of seizure pursuant to subsection (b), proceedings under subsection (d) shall be instituted promptly.

(d) Property taken or detained under this Section shall not be subject to replevin, but is deemed to be in the custody of the Director subject only to the order and decrees of the circuit court having jurisdiction over the forfeiture proceedings. When property is seized under this Act, the Director may:

(1) place the property under seal; or

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

(3) require the sheriff of the county in which the seizure occurs to take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(e) No disposition may be made of property under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application therefor, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court.

(f) When property is forfeited under this Act the Director may:

(1) retain it for official use; or

(2) require the sheriff of the county in which the forfeiture occurs to take custody of the property and remove it for disposition in accordance with law; or

(3) forward it to the Bureau of Narcotics and Dangerous Drugs, United States Department of Justice, or its successor agency, for disposition.

Section 13. (a) In addition to any other remedies the Director is authorized to apply to any circuit court for, and such circuit court shall have jurisdiction upon hearing and for cause shown, to grant a temporary or permanent injunction, without bond, restraining any person

from violating any provision of this Act, whether or not there exists an adequate remedy at law.

(b) A conviction or acquittal, under the laws of the United States or of any State relating to Cannabis for the same act is a bar to prosecution in this State.

Section 14. (a) The Director shall cooperate with Federal and other State agencies in discharging his responsibilities concerning traffic in cannabis and in suppressing the use of cannabis. To this end he may:

(1) arrange for the exchange of information among governmental officials concerning the use of cannabis;

(2) coordinate and cooperate in training programs concerning cannabis law enforcement at local and State levels;

(3) cooperate with the Bureau of Narcotics and Dangerous Drugs, United States Department of Justice, or its successor agency; and

(4) conduct programs of eradication aimed at destroying wild illicit growth of plant species from which cannabis may be extracted.

Section 15. The Department of Mental Health shall encourage research on cannabis. In connection with the research, and in furtherance of the purposes of this Act, it may:

(1) establish methods to assess accurately the effect of cannabis;

(2) make studies and undertake programs of research to:

(i) develop new or improved approaches, techniques, systems, equipment and devices to strengthen the enforcement of this Act;

(ii) determine patterns of use of cannabis and its social effects; and

(iii) improve methods for preventing, predicting, understanding, and dealing with the use of cannabis;

(3) enter into contracts with public agencies, educational institutions, and private organizations or individuals for the purpose of conducting research, demonstrations, or special projects which relate to the use of cannabis.

Section 16. It is not necessary for the State to negate any exemption or exception in this Act in any complaint, information, indictment or other pleading or in any trial, hearing, or other proceeding under this Act. The burden of proof of any exemption or exception is upon the person claiming it.

Section 17. It is hereby made the duty of the Department of Law Enforcement, all peace officers within the State and of all State's Attorneys, to enforce all provisions of this Act and to cooperate with all agencies charged with the enforcement of the laws of the United States, of this State, and of all other states, relating to cannabis.

Section 18. Prosecution for any violation of law occurring prior to the effective date of this Act is not affected or abated by this Act. If the offense being prosecuted would be a violation of this Act, and has not reached the sentencing stage or a final adjudication, then for purposes of penalty the penalties under this Act apply if they are less than under the prior law upon which the prosecution was commenced.

Section 19. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared severable.

CANNABIS CONTROL ACT

*Penalty Structure

Weight of Marihuana	**Penalty**
less than 2.5 grams	possession: 90 days (Sec. 4) **manufacture: 180 days (Sec. 5)
2.5 grams to 10 grams	possession: 180 days (Sec. 4) manufacture: not more than 1 year or 1 - 2 years (Sec. 5)
10 to 30 grams	possession: not more than 1 year (Sec. 4) subsequent offense: 1 - 2 years manufacture: not more than 1 year or 1 - 3 years (Sec. 5) subsequent offense: 1 - 4 years
30 to 500 grams	possession: 1 - 3 years (Sec. 4) subsequent offense: 2 - 6 years manufacture: 1 - 4 years (Sec. 5) subsequent offense: 2 - 8 years
over 500 grams	possession: 1 - 5 years (Sec. 4) subsequent offense: 2 - 7 years manufacture: 1 - 7 years (Sec. 5) subsequent offense: 2 - 10 years

The calculated conspiracy provisions that are included in the **Illinois Controlled Substances Act** are also included and carry a 3 - 10 year sentence and a fine of $200,000.00. For a subsequent offense of the calculated conspiracy provisions of the **Cannabis Control Act** the penalty is 5 - 20 years. (Sec. 9)

The conditional discharge provisions for first offenses under conditions of probation are also carried forward. (Sec. 10)

Delivery by an 18-year-old to a person under 18, 3 years his junior, is punishable by twice the maximum penalty otherwise authorized. (Sec. 7)

Producing the plant Cannabis Sativa L: not more than 1 year or $1,500 fine, or both. (Sec. 8)

* This chart provides general penalty guidelines and should be checked against the **Cannabis Control Act** at all times.

** "Manufacture" is used in the chart as a short form of the complete definition, "manufacture or deliver or possess with intent to manufacture or deliver."

APPENDIX 4

Public Act 77-774
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 95½, Sections 120.1 et seq.)

Amends the title of the Drug Addiction Act to the Controlled Substances Addiction Act, and the Narcotic Advisory Council to the Controlled Substances Advisory Council, defines addicts, addiction and drugs in terms of the Illinois Controlled Substances Act introduced at the 77th General Assembly.

An Act to amend Sections 1, 2, 3.01, 3.03, 3.04, 3.05, 4, 5, 6, 6.01, 8 and 11 and the title of and to repeal Section 3.02 of the "Drug Addiction Act", approved August 18, 1965, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 1, 2, 3, 3.01, 3.02, 3.03, 3.04, 3.05, 3.09, 4, 5, 6, 6.01, 6.02, 6.04, 6.05, 6.06, 6.08, 6.10, 6.13, 8 and 11 of the "Drug Addiction Act" approved August 18, 1965, as amended, are amended to read as follows:

Section 1. This Act shall be known and may be cited as the "Dangerous Drug Abuse Act."

Section 2. It is the public policy of this State that the human suffering and social and economic loss caused by addiction to controlled substances and the use of cannabis are matters of grave concern to the people of the State. It is imperative that a comprehensive program be established and implemented through the facilities of the State, counties, municipalities, the Federal Government, and local and private agencies to prevent such addiction and abuse; to promote research on the effects and consequences of the abuse of controlled substances and use of cannabis; to study the problem of the abuse of controlled substances and use of cannabis in this State and inform the public as to its findings; and to provide diagnosis, treatment, care and rehabilitation for controlled substance addicts to the end that these unfortunate individuals may be restored to good health and again become useful citizens in the community.

Section 3. As used in this Act, unless the context otherwise requires, the terms defined in Section 3.01 through 3.08 have the meanings ascribed to them in these Sections.

Section 3.01. "Controlled substance" means any substance which is enumerated in the Schedules of Article II of the "Illinois Controlled Substances Act", enacted by the 77th General Assembly, as heretofore or hereafter amended.

Section 3.02. "Dangerous drug" means controlled substances and cannabis, as herein defined.

Section 3.03. "Addict" means any person who habitually uses any controlled substance so as to endanger the public morals, health, safety or welfare or who is so far addicted to the use of controlled substances as to have lost the power of self control with reference to his addiction.

Section 3.04. "Addiction" means such habitual use of any controlled substance so as to endanger the public morals, health, safety or welfare, or the use of controlled substances so that the user has lost the power of self control with reference to his addiction.

Section 3.05. "Council" means the Dangerous Drugs Advisory Council created by this Act.

Section 3.09. "Cannabis" means any substance so defined in the "Cannabis Control Act" enacted by the 77th General Assembly.

Section 4. There is established a Dangerous Drugs Advisory Council whose membership shall consist of the Director of Mental Health, who shall be chairman, the Director of the Department of Law Enforcement, the Director of Public Health, the Superintendent of the Illinois Bureau of Investigation, the Director of the Drug Abuse Program of the Department of Mental Health, the State's Attorney of Cook County, a State's Attorney from a county other than Cook designated by the Director of Mental Health, the Director of Vocational Rehabilitation, the Director of Public Aid, the Director of Children and Family Services, a judge of the Circuit Court of Cook County designated by the Chief Judge of that court, the Superintendent of Police of the City of Chicago, the Commissioner of the Board of Health of the City of Chicago, 3 members of the House of Representatives appointed by the Speaker thereof, 3 members of the Senate appointed by the President pro tempore, and 8 additional citizen members who shall be appointed by the Governor with the advice and consent of the Senate. Each of the non-appointive governmental members may delegate a representative to serve in his place by written notice to the other members of the Council. No more than 2 members of the General Assembly from the House of Representatives and Senate, respectively, may be of the same political party, and all General Assembly members shall serve until their respective successors are appointed or until termination of their legislative service, whichever first occurs. In appointing citizen members, the Governor shall give due regard to their knowledge and experience in the fields of medicine, law enforcement, correction activities or social welfare. The terms of office of each of the citizen members of the Council shall be for 3 years, except that of the members first appointed, 2 shall be appointed for a term of one year, 2 for 2 years, and 2 for 3 years. Vacancies in the citizen membership shall be filled for the unexpired term by appointment in like manner as for original appointments, and the appointive members shall continue in office until their successors are appointed and have qualified.

The Council shall organize annually by electing a vice-chairman from its membership, and a secretary who need not be a member. The Council shall adopt such rules as it deems necessary.

The members of the Council shall receive no compensation for their services but shall be reimbursed for all expenses actually and necessarily incurred by them in the performance of their duties under this Act, and within the amounts made available therefor.

The Council shall meet from time to time as it considers appropriate at the call of the chairman or upon the request of any 4 members of the Council. The Department of Mental Health shall provide housekeeping, secretarial and consultant services to the Council.

Section 5. The Dangerous Drugs Advisory Council shall consult with the various State departments and agencies of State Government, interested public and private bodies and agencies and the Federal government, all in connection with:

(a) Formulation of a comprehensive plan for the long-range development of adequate services and facilities for the prevention and control of addiction to controlled substances and the abuse of dangerous drugs, the treatment and rehabilitation of controlled substance addicts, and the revision of such plan from time to time, through the utilization of Federal, State, county, municipal, local, and private resources;

(b) The promotion, development, establishment, coordination and conduct of unified programs in the fields of controlled substance addiction and use of cannabis, for the purposes of education, diagnosis, treatment, after-care, community referral, rehabilitation, prevention and control, in cooperation with other Federal, State, county, municipal, local and private agencies; and

(c) Review of existing laws pertaining to and dangerous drugs, including criminal laws, to determine their effectiveness in preventing continued dangerous drug abuse and criminal activities related to dangerous drug abuse and their effects on dangerous drug abusers.

These plans and programs shall have due regard for and shall be consistent with the responsibilities of law enforcement agencies to control and suppress the illegal distribution and use of dangerous drugs.

Section 6. With the advice of the Dangerous Drugs Advisory Council and with the assistance of any interdepartmental council or committee heretofore or hereafter established and charged with responsibility for interdepartmental cooperation and program development in the fields of addiction and abuse of dangerous drugs, the Department of Mental Health shall have the powers and perform the duties specified in Sections 6.01 through 6.12.

The Director of Mental Health may designate a person with the Department of Mental Health to coordinate and conduct the programs and procedures established herein and such person shall have supervision of the care, treatment and rehabilitation programs established under this Act.

Section 6.01. Establish unified programs for education, prevention, diagnosis, treatment, aftercare, community referral, rehabilitation and control in the fields of dangerous drug addiction and abuse based on the comprehensive plan formulated by the Council under this Act.

Section 6.02. Promote basic and clinical research in the treatment of addiction and abuse of dangerous drugs.

Section 6.04. Provide public education regarding the problems of addiction and abuse of dangerous drugs. In this regard, the Department of Mental Health shall conduct a study to determine the feasibility of establishing a comprehensive educational program for uniform and universal administration in all primary and secondary schools in this State. Such program should be designed to educate school children on the subject of dangerous drug abuse so as to discourage and prevent their abusing dangerous drugs. The results of this study shall be submitted to the Governor, all members of the General Assembly, and all members of the Council, one year after the effective date of this subsection.

Section 6.05. Disseminate information relating to available services for addicts and abusers of dangerous drugs.

Section 6.06. Explore the feasibility of drafting a "Uniform Drug Arrest Form" to be used by all law enforcement agencies in this State. This form would be completed in all arrests involving dangerous drugs. The information contained in the completed form would include all data traditionally included in police forms as well as such specialized facts as may be of relevance to the Council in drafting its annual report.

Section 6.08. Establish and operate rehabilitation centers and other necessary facilities for the supervision and treatment of addicts and abusers of dangerous drugs.

Section 6.10. Approve facilities and services for the treatment, care or rehabilitation of addicts and abusers of dangerous drugs in accordance with requirements established by the Department, and assign or transfer addicts and abusers of dangerous drugs certified to its care to such facilities.

Section 6.13. Submit a detailed and comprehensive written report, on or before February 1st of each year, to the General Assembly and the Governor on the problem of dangerous drug abuse in Illinois during the preceding year. The report shall encompass all dangerous drugs as defined in this Act and others which, in the view of the Council, represent a hazard to the public health, safety and welfare of the citizens of Illinois. This report shall include, but is not limited to:

(a) a compilation of data and statistics concerning the nature and scope of dangerous drug abuse in this State; and

(b) an analysis of the correlation between the incidence of dangerous drug abuse and the incidence of crimes in general in this State, whether or not such crimes have arisen from violations of the "Illinois Controlled Substances Act" or the "Cannabis Control Act"; and

(c) a compilation of dangerous drug arrest statistics and conviction rates for persons arrested and convicted under the "Illinois Controlled Substances Act" and the "Cannabis Control Act"; and

(d) the incidence of recidivism among persons convicted under the "Illinois Controlled Substances Act" and the "Cannabis Control Act"; and

(e) a compilation of statistics concerning deaths due to dangerous drug overdoses in this State; and

(f) a progress analysis of correctional and rehabilitative methods and efforts undertaken by State and various private agencies; and

(g) a synopsis of medical advances and studies which are relevant to the design of future attempts to effectively manage the dangerous drug abuse problem in this State; and

(h) an analysis of the effectiveness of the laws of this State relating to dangerous drugs, including any recommended changes in these laws; and

(i) other pertinent matters which the Council shall deem relevant to the analysis of the State's progress in combating dangerous drug abuse.

To this end, the Council is authorized to demand from all law enforcement agencies in this State copies of identification and arrest data.

Section 8. An addict charged with or convicted of a crime is eligible to elect treatment under the supervision of the Department instead of prosecution or probation, as the case may be, unless (a) the crime is a crime of violence, (b) the crime is a violation of Sections 401, 402 (a), 405 and 407 of the Illinois Controlled Substances Act, enacted by the 77th General Assembly, or Sections 4 (d), 5 (d), 7 or 9 of the Cannabis Control Act, enacted by the 77th General Assembly, (c) the addict has a record of 2 or more convictions of a crime of violence, (d) other criminal proceedings alleging commission of a felony are pending against the addict, or (e) the addict is on probation or parole and the appropriate parole or probation authority does not consent to that election, or (f) the addict elected and was admitted to a treatment program on two prior occasions within any consecutive two year period. An eligible addict may not be admitted to a treatment program, however, unless the authorities concerned consent as hereinafter set forth.

Section 11. Acceptance of treatment for controlled substance addiction under the supervision of the Department may be made a condition of parole, and failure to comply with such treatment may be treated as a violation of parole. The Department shall establish the conditions under which a parolee is accepted for treatment. No parolee may be placed under supervision of the Department for treatment unless the Department accepts him for treatment. The Department shall make periodic progress reports regarding each such parolee to the appropriate parole authority and shall report failures to comply with the prescribed treatment program.

Section 2. The title of said Act is amended to read as follows:

AN ACT in relation to the prevention and treatment of dangerous drug addiction and abuse and the rehabilitation of addicts, creating a Dangerous Drugs Advisory Council and defining its powers and duties, and defining the powers and duties of the Department of Mental Health in such prevention, treatment and rehabilitation.

APPENDIX 5

Public Act 77-763
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 111½, Section 191)

Amends the Out-Patient Clinics in Chicago Act by substituting controlled substances for narcotics so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Section 1 of and the title of "An Act authorizing the Department of Public Health to acquire and operate narcotic out-patient clinics in the City of Chicago and making an appropriation therefor," approved July 25, 1951, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Section 1 of "An Act authorizing the Department of Public Health to acquire and operate narcotic out-patient clinics in the city of Chicago and making an appropriation therefor," approved July 25, 1951, as amended, is amended to read as follows:

Sec. 1. The Department of Public Health is authorized to establish three out-patient clinics in the city of Chicago for the treatment of persons addicted to controlled substances and users of cannabis. Each clinic shall be located at a recognized hospital in the city and one clinic shall be located on the north side, one on the south side and one on the west side. The clinic shall be properly staffed in order to furnish treatment and rehabilitation for controlled substance addicts and users of cannabis.

Section 2. The title of said Act is amended to read as follows:

AN ACT authorizing the Department of Public Health to acquire and operate controlled substance out-patient clinics in the city of Chicago, and making an appropriation therefor.

APPENDIX 6

Public Act 77-764
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 23, Section 2801)

Amends the State Reformatory for Women Act by substituting controlled substance addicts for drug addicts so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Section 3 of "An Act to establish and provide for a State Reformatory for Women," approved June 30, 1927, as amended, is amended to read as follows:

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Section 3 of "An Act to establish and provide for a State Reformatory for Women," approved June 30, 1927, as amended, is amended to read as follows:

Sec. 3. The Department of Corrections shall cause to be prepared plans and specifications for the necessary buildings and improvements for the reformatory. Such buildings and improvements shall be erected and constructed in accordance with the provisions of Sections 28 and 49 of the Civil Administrative Code of Illinois. The buildings shall include cottages so that the women committed to the reformatory may be classified and grouped properly and their occupations and training may be diversified. The buildings shall also include proper hospital and clinical facilities with special provision for the treatment of venereal diseases and addiction to controlled substances and use of cannabis. The Department shall furnish and equip the buildings and improvements ready for use.

APPENDIX 7

Public Act 77-765
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 56½, Section 501 et seq.)

Amends the Illinois Food, Drug and Cosmetic Act by incorporating by reference the prescription requirements of the Illinois Controlled Substances Act and by substituting controlled substances for narcotic drug so as to conform to the Uniform Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 16 and 24 of the "Illinois Food, Drug and Cosmetic Act", approved June 29, 1967, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 16 and 24 of the "Illinois Food, Drug and Cosmetic Act", as amended, are amended to read as follows:

Sec. 16. (a) A drug intended for use by man which (A) is a habit-forming drug to which Section 15 (d) applies; or (B) because of its toxicity or other potentiality for harmful effect or the method of its use or the collateral measures necessary to its use is not safe for use except under the supervision of a practitioner licensed by law to administer such drug; or (C) is limited by an approved application under Section 505 of the Federal Act or Section 17 of this Act to use under the professional supervision of a practitioner licensed by law to administer such drug, shall be dispensed only in accordance with the provisions of the "Illinois Controlled Substances Act" enacted by the 77th General Assembly. The act of dispensing a drug contrary to the provisions of this paragraph shall be deemed to be an act which results in a drug being misbranded while held for sale.

(b) Any drug dispensed by filling or refilling a written or oral prescription of a practitioner licensed by law to administer such drug shall be exempt from the requirements of Section 15, except subsections (a), (i) (2) and (3), (k), and (l), and the packaging requirements of subsections (g) and (h), if the drug bears a label containing the name and address of the dispenser, the serial number and date of the prescription or of its filling, the name of the prescriber and, if stated in the prescription, the name of the patient, and the directions for use and the cautionary statements, if any, contained in such prescription. This exemption shall not apply to any drug dispensed in the course of the conduct of business of dispensing drugs pursuant to diagnosis by mail, or to a drug dispensed in violation of paragraph (a) of this Section.

(c) The Director may by regulation remove drugs subject to Section 15(d) and Section 17 from the requirements of paragraph (a) of this Section when such requirements are not necessary for the protection of the public health.

(d) A drug which is subject to paragraph (a) of this Section shall be deemed to be misbranded if at any time before dispensing its label fails to bear the statement "Caution: Federal Law Prohibits Dispensing Without Prescription" or "Caution: State Law Prohibits Dispensing Without Prescription." A drug to which paragraph (a) of this Section does not apply shall be deemed to be misbranded if at any time prior to dispensing its label bears the caution statement quoted in the preceding sentence.

(e) Nothing in this Section shall be construed to relieve any person from any requirement prescribed by or under authority of law with respect to controlled substances now included or which may hereafter be included within the classifications of controlled substances cannabis as defined in the applicable Federal and State laws relating to controlled substances cannabis.

Sec. 24. Nothing in this Act shall be construed to limit or repeal any provisions of the Illinois Controlled Substances Act.

APPENDIX 8

Public Act 77-766
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 100½, Section 14 et seq.)

Amends the Nuisances Act by substituting the Department of Law Enforcement for the Division of Narcotic Control and by substituting controlled substances for narcotic drugs so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly. Provides that proceeds of property sold be paid to the Common School Fund.

AN ACT to amend Sections 1, 2, 3, 6, 7, 11 and 13 and the title of "An Act in relation to places used for the purpose of using, keeping or selling narcotic drugs," approved July 5, 1957, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 1, 2, 3, 6, 7, 11 and 13 of "An Act in relation to places used for the purpose of using, keeping or selling narcotic drugs," approved July 5, 1957, as amended, are amended to read as follows:

Sec. 1. As used in this Act unless the context otherwise requires:

"Department" means the Department of Law Enforcement of the State of Illinois.

"Controlled Substances" means any substance as defined and included in the Schedules of Article II of the "Illinois Controlled Substances Act," and cannabis as defined in the "Cannabis Control Act" enacted by the 77th General Assembly.

"Place" means any store, shop, warehouse, dwelling house, building, apartment or any place whatever.

"Nuisance" means any place which is resorted to for the purpose of unlawfully selling, serving, storing, keeping, giving away or using controlled substances.

"Person" means any corporation, association, partner, or one or more individuals.

Sec. 2. All places and the fixtures and movable contents thereof, used for the purpose of unlawfully selling, serving, storing, keeping, giving away or using controlled substances are hereby declared to be nuisances and may be abated as hereinafter provided and the owners, agents, occupants of and any other person using any such place may be enjoined as hereinafter provided.

Sec. 3. The Department or the State's Attorney or any citizen of the county in which a nuisance exists may maintain a complaint in the name of the People of the State of Illinois, to enjoin all persons from maintaining or permitting such nuisance, to abate the same and to enjoin the use of any such place for the period of one year.

Upon the filing of a complaint by the State's Attorney or the Department in which the complaint states that irreparable injury, loss or damage will result to the People of the State of Illinois, the court shall issue a temporary injunction without notice enjoining the maintenance of such nuisance, upon testimony under oath, sufficient, if sustained, to justify the court in issuing a temporary injunction upon a hearing after notice. Every such temporary injunction granted without notice shall be endorsed with the date and hour of issuance, shall be entered of record, and shall expire by its terms within such time after entry, not to exceed 10 days as fixed by the court, unless the temporary injunction, for good cause is extended for a like period or unless the party against whom the order is directed consents that it may be extended for a longer period. The reason for extension shall be entered of record. In case a temporary injunction is granted without notice, the motion for a permanent injunction shall be set down for hearing at the earliest possible time and takes precedence over all matters except older matters of the same character, and when the motion comes on for hearing, the Department or State's Attorney, as the case may be, shall proceed with the application for a permanent injunction, and, if he does not do so, the court shall dissolve the temporary injunction. On 2 days notice to the Department or State's Attorney, as the case may be, the defendant may appear and move the dissolution or modification of such temporary injunction and in that event the court shall proceed to hear and determine such motion as expeditiously as the ends of justice require.

Upon the filing of the complaint by a citizen or the Department or the State's Attorney (in cases in which the Department or State's Attorney do not request an injunction without notice) in any court of competent jurisdiction, the court in term time, or a judge in vacation, if satisfied that the nuisance complained of exists, shall allow a temporary writ of injunction, with bond unless the petition is filed for the Department or State's Attorney, in such amount as the court may determine, enjoining the defendant from maintaining any such nuisance within the jurisdiction of the court issuing such writ: Provided, that no such injunction shall issue, except on behalf of an owner or agent, unless it be made to appear to the satisfaction of the court that the owner or agent of such place, knew or had been personally served with a notice signed by the petitioner; And, provided, that such notice has been served upon such owner or such agent of such place at least five days prior thereto, that such place, specifically describing the same, was being so used, naming the date or dates of its being so used, and that such owner or agent had failed to abate such nuisance, or that upon diligent inquiry such owner or agent could not be found within Illinois for the service of such preliminary notice. The lessee, if any, of such place shall be made a party defendant to such petition.

In all cases in which the complaint is filed by a citizen, such complaint shall be verified.

Sec. 6. If the existence of the nuisance is established, the court shall enter a decree perpetually restraining all persons from maintaining or permitting such nuisance, and from using the place in which the same is maintained for any purpose for a period of one year thereafter, unless such decree is sooner vacated, as hereinafter provided, and perpetually restraining the defendant from maintaining any such nuisance within the jurisdiction of the court. While the decree remains in effect, such place shall be in the custody of the court. An order of abatement shall also issue as a part of such decree, which order shall direct the sheriff of the county to remove from such place all fixtures and movable property used in conducting or aiding or abetting such nuisance, and to sell the same in the manner provided by law for the sale of chattels under execution, and to close such place against its use for any purpose, and to keep it closed for a period of one year unless sooner released as hereinafter provided. The sheriff's fees for removing and selling the movable property shall be taxed as a part of the costs, and shall be the same as those for levying upon and selling like property under execution. For closing the place and keeping it closed, the court shall allow a reasonable fee to be taxed as part of the costs: Provided, that no injunction shall issue against an owner, nor shall an order be entered requiring that any place be closed or kept closed, if it appears that such owner and his agent have in good faith endeavored to prevent such nuisance or did not have knowledge of such nuisance except in cases in which the Department or State's Attorney states in his complaint that immediate and irreparable injury will result to the People of the State of Illinois, then a temporary writ of injunction may issue. Nothing in this act contained shall authorize any relief respecting any other place than that in which such nuisance exists.

Sec. 7. The proceeds of the sale of the movable property shall be applied in payment of the costs of the proceeding, and the balance, if any, shall be paid to the State Treasurer for deposit in the Common School Fund of this State.

Sec. 11. If any lessee or occupant shall use leased premises for the purpose of unlawful using, keeping or selling controlled substances or shall permit them to be used for any such purposes, the lease or contract for letting such premises shall, at the option of the lessor, become void, and the owner may have the like remedy to recover possession thereof as against a tenant holding over after the expiration of his term.

Sec. 13. Nothing contained in this Act shall apply to any unlawful act which results from failing to comply with the provisions prescribed in the "Illinois Controlled Substances Act," enacted by the 77th General Assembly.

Section 2. The title of said Act is amended to read as follows:

"An Act in relation to places used for the purpose of using keeping or selling controlled substances and cannabis."

APPENDIX 9

Public Act 77-767
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 122, Section 27-10)

Amends Section 27-10 of The School Code (Courses of Study — Special Instruction) by substituting controlled substance for narcotics so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Section 27-10 of "The School Code", approved March 18, 1961, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Section 27-10 of "The School Code", approved March 18, 1961, as amended, is amended to read as follows:

Sec. 27-10. Nature and effect of alcoholic drinks and controlled substances and cannabis. The nature of alcoholic drinks and controlled substances and cannabis and their effects on the human system shall be taught in connection with the various divisions of physiology and hygiene, as thoroughly as are other branches, in all schools under State control or supported wholly or in part by public money, and also in all schools connected with reformatory institutions. All pupils in such schools below the second year of high school and above the third year of elementary school work or in corresponding classes of ungraded schools shall be taught and shall study this subject every year from suitable textbooks in their hands, not less than 4 lessons a week for 10 or more weeks of each year, and must pass tests in this as in other studies. In all such schools pupils in the lowest 3 elementary school years, or in corresponding classes in ungraded schools, shall each year be instructed in this subject orally for not less than 3 lessons a week for 10 weeks in each year, by teachers using textbooks adapted for such oral instruction as a guide and standard. The textbooks shall be graded to the capacity of the fourth year, intermediate elementary and high school pupils, or to corresponding classes in ungraded schools. For students below high school grade the textbooks shall give at least one-fifth their space, and for students of high school grade shall give not less than 20 pages, to this subject. The pages on this subject in a separate chapter at the end of the book shall not be counted in determining the minimum. In all State universities and teachers' training classes and teachers' institutes, adequate time and attention shall be given to instruction in the best method of teaching such subject and no teacher shall be certificated who has not passed a satisfactory examination in this subject and the best methods of teaching it. Any school officer who neglects or fails to comply with the provisions of this section shall forfeit and pay for each offense the sum of not less than $5 nor more than $25.

APPENDIX 10

Public Act 77-768
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 38 Section 117-1)

Amends the Code of Criminal Procedure of 1963 by setting forth the nonprobational offenses of the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Section 117-1 of the "Code of Criminal Procedure of 1963", approved August 14, 1963, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Section 117-1 of the "Code of Criminal Procedure of 1963", approved August 14, 1963, as amended, is amended to read as follows:

Sec. 117-1. Admission to Probation.

(a) A person who has been found guilty of any offense except a capital offense, a violation of Sections 401 (a), 402 (a), 405 and 407 of the "Illinois Controlled Substances Act" enacted by the 77th General Assembly, a violation of Section 9 of the "Cannabis Control Act" enacted by the 77th General Assembly or rape may be admitted to probation when it appears that:

(1) The defendant is not likely to commit another offense;

(2) The public interest does not require that the defendant receive the penalty provided for the offense; and

(3) The rehabilitation of the defendant does not require that he receive the penalty provided for the offense.

(b) The term of probation may be for any period not less than 6 months and not to exceed 5 years. The court may for good cause extend the period of probation for not more than an additional 2 years.

(c) A person admitted to probation shall remain subject to the jurisdiction of the court.

(d) The judgment of guilty entered prior to the admission of defendant to probation shall be a final judgment subject to review under Article 121 of this Code.

APPENDIX 11

Public Act 77-769
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 127, Sections 53 and 55a)

Amends the Civil Administrative Code by substituting Department of Law Enforcement for Division of Narcotic Control and controlled substance addicts for narcotic and dangerous drug addicts so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 53 and 55a of "The Civil Administrative Code of Illinois," approved March 7, 1917, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 53 and 55a of "The Civil Administrative Code of Illinois," approved March 7, 1917, as amended, are amended to read as follows:

Sec. 53. The Department of Mental Health has power:

1. To exercise the powers and duties set forth in "An Act codifying the powers and duties of the Department of Mental Health, and repealing certain Acts herein named", approved August 2, 1961, as heretofore or hereafter amended;

2. To administer the provisions of the "Mental Health Code", approved July 18, 1963, or as hereafter amended, which pertain to the responsibilities of the Department of Mental Health;

3. To treat patients who are committed under Section 6 of "An Act in relation to controlled substance addicts, and unlawful users of controlled substances and cannabis and providing for their commitment, detention and supervision", approved July 5, 1957, as heretofore and hereafter amended, and to exercise the other powers and fulfill such other duties assigned the Department by that Act;

4. To exercise the powers and fulfill the duties assigned the Department by the "Dangerous Drug Abuse Act", approved August 18, 1965, as now or hereafter amended.

5. To exercise the powers and fulfill the duties assigned the Department by "An Act concerning damages caused by escaped inmates of charitable, penal, reformatory or other institutions over which the State has control", approved June 21, 1935, as heretofore and hereafter amended;

6. To initiate injunction proceedings wherever it appears to the Director of Mental Health that any person, group of persons, or corporation is engaged or about to engage in any acts or practices which constitute or will constitute a violation of the "Mental Health Code" or any rule or regulation prescribed under authority thereof. The Director of Mental Health may, in his dis-

cretion, through the Attorney General, apply for an injunction, and upon a proper showing, any circuit court may issue a permanent or temporary injunction or restraining order without bond to enforce such Acts in addition to the penalties and other remedies provided in such Acts and either party to such suit may prosecute an appeal from the order or judgment of the court;

7. To appoint, subject to the "Personnel Code", persons to be members of a police and security force. Members of the police and security force shall be peace officers and as such have all powers possessed by policemen in cities, and sheriffs, including the power to make arrests on view or warrants of violations of state statutes or city or county ordinances; except that such power shall be exercised only in counties of more than 500,000 population when such exercise is required for the protection of Department properties and interests in its personnel, and otherwise, within such counties, when specifically requested by appropriate state or local law enforcement officials; and except that members of such police and security force shall have no power to serve and execute civil processes.

Sec. 55a. The Department of Law Enforcement shall have power:

1. To exercise the rights, powers and duties which have been vested by law in the Department of Public Safety as the successor of the State Fire Marshal, deputy State Fire Marshal, inspectors and other officers and employees of the State Fire Marshal;

2. To exercise the rights, powers and duties which have been vested in the Department of Public Safety by "An Act in relation to State highway police and to repeal an Act herein named" approved July 20, 1949, as amended;

3. To exercise the rights, powers and duties which have been posted in the Department of Public Safety by "An Act in relation to the establishment and operation of radio broadcasting stations and the acquisition and installation of radio receiving sets for police purposes," approved July 7, 1931, as amended;

4. To exercise the rights, powers and duties which have been vested in the Department of Public Safety by "An Act in relation to criminal identification and investigation," approved July 2, 1931;

5. To establish and maintain a bureau of investigation which shall (a) investigate the origins, activities, personnel and incidents of crime and the ways and means to redress the victims of crimes, and study the impact, if any, of legislation relative to the effusion of crime and growing crime rates, and enforce the criminal laws of this State related thereto, (b) enforce all laws regulating the production, sale, prescribing, manufacturing, administering, transporting, furnishing, having possession, dispensing, delivering, distributing, or use of controlled substances and cannabis, (c) employ skilled experts, scientists, technicians, investigators or otherwise specially qualified persons to aid in preventing or detecting crime, apprehending criminals, or preparing and presenting evidence of violations of the criminal laws of the state, (d) cooperate with the police of cities, villages and incorporated towns, and with the police officers of any county, in enforcing the laws of the State and in making arrests and recovering property, (e) apprehend and deliver up any person charged in this State or any other state of the United States with treason, felony, or other crime, who has fled from justice and is found in this State, and (f) conduct such other investigations as may be provided by law. Investigators within the bureau are conservators of the peace and as such have all the powers possessed by policemen in cities and sheriffs, except that they may exercise such powers anywhere in the State in cooperation with and after contact with the local law enforcement officials.

6. To establish and maintain a bureau of identification which shall (a) be a central repository and custodian of criminal statistics for the State, (b) procure and file for record photographs, plates, outline pictures, measurements, descriptions of all persons who have been arrested on a charge of violation of a penal statute of this State, (c) procure and file for record such information as is necessary and helpful to plan programs of crime prevention, law enforcement and criminal justice, (d) procure and file for record such copies of fingerprints, as may be required by law, of all persons arrested on charges of violating any penal statute of the state, (e) establish general and field crime laboratories, (f) register and file for record such information as may be required by law for the issuance of firearm owner's identification cards, (h) employ polygraph operators, laboratory technicians and other specially qualified persons to aid in the identification of criminal activity, (i) keep a record, as may be required by law, of all fires occurring in the State, together with all facts, statistics and circumstances, including the origin of the fires, and (j) undertake such other identification, information, laboratory, statistical or registration activities as may be required by law.

Photographs, fingerprints or other records of identification so taken shall, upon the acquittal of a person charged with the crime or upon his being released without being convicted, be returned to him, except that nothing herein shall prevent the Department of Law Enforcement from maintaining all records of any person who is admitted to probation upon terms and conditions and who fulfills those terms and conditions pursuant to Section 410 of the "Illinois Controlled Substances Act", and Section 10 of the "Cannabis Control Act," enacted by the 77th General Assembly;

7. To establish and maintain a bureau of communications and information which shall (a) acquire and operate one or more radio broadcasting stations in the State to be used for police purposes, (b) operate a statewide communications network to gather and disseminate information for law enforcement agencies, (c) operate an electronic data processing and computer center for the storage and retrieval of data pertaining to criminal activity, (d) undertake such other communication activities as may be required by law.

8. To provide, as may be required by law, assistance to local law enforcement agencies through (a) training, management and consultant services for local law enforcement agencies and (b) the pursuit of research and the publication of studies pertaining to local law enforcement activities;

9. To exercise the rights, powers and duties which have been vested in the Department of Law Enforcement and the Director of the Department of Law Enforcement by "An Act in relation to control and regulation of controlled substances, and to make an appropriation therefor," approved July 5, 1957;

10. To exercise the rights, powers and duties which have been vested in the Department of Public Safety by the "Boiler Safety Act," approved August 7, 1951, as amended;

11. To exercise the rights, powers and duties which have been vested in the Department of Public Safety by "An Act in relation to the regulation of traffic", approved July 9, 1935, as amended;

12. To exercise the rights, powers and duties which have been vested in the Department of Public Safety by "An Act relating to the acquisition, possession and transfer

of firearms and firearm ammunition, to provide a penalty for the violation thereof, and to make an appropriation in connection therewith", approved August 3, 1967;

13. To enforce and administer such other laws in relation to law enforcement as may be vested in the Department;

14. To transfer jurisdiction of any realty title to which is held by the State of Illinois under the control of the Department to any other Department of the State Government or to the State Employees Housing Commission, or to acquire or accept Federal lands, when such transfer, acquisition or acceptance is advantageous to the State and is approved in writing by the Governor;

15. With the written approval of the Governor, to enter into agreements with other departments created by this Act, for the furlough of inmates of the penitentiary to such other departments for their use in research programs being conducted by them.

For the purpose of participating in such research projects, the Department may extend the limits of the inmates' place of confinement, to whom there is reasonable cause to believe that he will honor his trust by authorizing him, under prescribed conditions, to leave the confines of the place unaccompanied by a custodial agent of the Department. The Department shall make rules governing the transfer of the inmate to the requesting other department having the approved research project, and the return of such inmate to the unextended confines of the penitentiary. Such transfer shall be made only with the consent of the inmate.

The willful failure of a prisoner to remain within the extended limits of his confinement or to return within the time or manner prescribed to the place of confinement designated by the Department in granting such extension shall be deemed an escape from custody of the Department and punishable as provided in Section 17 of "An Act in relation to the Illinois State Penitentiary", approved June 30, 1933, as now or hereafter amended.

APPENDIX 12

Public Act 77-770
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 127, Section 55d et seq.)

Amends the title and text of An Act in relation to control and regulation of narcotic and dangerous drugs and to make an appropriation therefor by substituting controlled substances for narcotic and dangerous drugs or drugs and conforms the phraseology of the proscribed activities so as to be consistent with the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 2, 5, 6, 7 and 8 and the title of "An Act in relation to control and regulation of narcotic and dangerous drugs and to make an appropriation therefor," approved July 5, 1957, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 2, 5, 6, 7 and 8 of "An Act in relation to control and regulation of narcotic and dangerous drugs and to make an appropriation therefor," approved July 5, 1957, as amended, is amended to read as follows:

Sec. 2. The Department shall enforce all laws regulating the production, sale, prescribing, manufacturing, administering, transporting, having in possession, dispensing, delivering, distributing or use of controlled substances as defined in the "Illinois Controlled Substances Act," and cannabis as defined in the "Cannabis Control Act" enacted by the 77th General Assembly, as now or hereafter amended, and any other duties conferred upon the Department by law.

Sec. 5. The Department shall advise and inform local and other State law-enforcement officers of various controlled substances and cannabis law-enforcement practices and shall establish a central office where local and other State law-enforcement officers may report controlled substances and cannabis violations and obtain information about controlled substances and cannabis violators. Every local and other State law-enforcement officer shall report any violation of the controlled substances and cannabis laws of this State to the Department.

Sec. 6. The Department of Mental Health shall set the standards and requirements for the establishment of N-allylnormorphine and other clinics for the purpose of detection of controlled substances addiction and use of cannabis in connection with probation, parole and rehabilitation of violators of the "Illinois Controlled Substances Act", and the "Cannabis Control Act" enacted by the 77th General Assembly, as now or hereafter amended, and the apprehension and rehabilitation of violators of said Act.

The Department of Law Enforcement is authorized to establish laboratories for the purpose of testing of

controlled substances and cannabis which are seized and of research in determining what new controlled substances from time to time, which are marketed in this State, have addicting qualities.

The Department of Law Enforcement shall formulate, adopt and put into effect such reasonable rules and regulations as are necessary to carry out the provisions of this Act.

Sec. 7. The Director and the inspectors appointed by him, when authorized by the Director, may expend such sums as the Director deems necessary in the purchase of controlled substances and cannabis for evidence and in the employment of persons to obtain evidence.

Such sums to be expended shall be advanced to the officer who is to make such purchase or employment from funds appropriated or made available by law for the support or use of the Department on vouchers therefor signed by the Director. Any expenditures under this Section shall be audited by the Director and the audit approved by the Department of Finance.

Sec. 8. The Attorney General, upon the request of the Department, shall prosecute any violation of this Act, and of the "Illinois Controlled Substances Act," and the "Cannabis Control Act" enacted by the 77th General Assembly, as now or hereafter amended.

Section 2. The title of said Act is amended to read as follows:

"An Act in relation to control and regulation of controlled substances and cannabis and to make an appropriation therefor."

APPENDIX 13

Public Act 77-771
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 38, Sections 22-50 et seq.)

Amends the Hypodermic Syringes and Needles Act by substituting the Department of Law Enforcement for the Division of Narcotic Control and controlled substances for narcotic drugs so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 1, 3 and 5 of "An Act to regulate the possession, delivery, sale or exchange of hypodermic syringes, hypodermic needles, and similar instruments," approved July 11, 1955, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 1, 3 and 5 of "An Act to regulate the possesion, delivery, sale or exchange of hypodermic syringes, hypodermic needles, and similar instruments," approved July 11, 1955, as amended, are amended to read as follows:

Sec. 1. No person, not being a physician, dentist, chiropodist or veterinarian licensed under the laws of this State or of the state where he resides, or a registered professional nurse, or a registered embalmer, manufacturer or dealer in embalming supplies, wholesale druggist, manufacturing pharmacist, registered pharmacist, manufacturer of surgical instruments, industrial user, official of any government having possession of the articles hereinafter mentioned by reason of his official duties, nurse or a medical laboratory technician acting under the direction of a physician or dentist, employee of an incorporated hospital acting under the direction of its superintendent or officer in immediate charge, or a carrier or messenger engaged in the transportation of such articles, or the holder of a permit issued under Section 5 of this Act, or a farmer engaged in the use of such instruments on livestock, or a person engaged in chemical, clinical, pharmaceutical or other scientific research, shall have in his possession a hypodermic syringe, hypodermic needle, or any instrument adapted for the use of controlled substances or cannabis by subcutaneous injection.

Sec. 3. A record shall be kept by the person selling such syringe, needle or instrument which shall give the date of the sale, the name and address of the purchaser and a description of the instrument. This record shall at all times be open to inspection by the Department of Law Enforcement authorized agents of said Department and police authorities and police officers of cities, villages and towns.

Sec. 5. A licensed physician may direct a patient under his immediate charge to have in possession any

of the instruments specified in Sections 1 and 2 which may be dispensed by a registered pharmacist or assistant registered pharmacist in this state only (1) upon a written prescription of such physician, or (2) upon an oral order of such physician, which order is reduced promptly to writing and filed by the pharmacist, or (3) by refilling any such written or oral prescription if such refilling is authorized by the prescriber either in the original prescription or by oral order which is reduced promptly to writing and filed by the pharmacist in the same manner and under the same conditions as any other prescription issued by a practitioner licensed by law to write prescriptions, or (4) upon a signed statement of the patient, upon proper identification, stating that the prescriptions or instruments specified in Sections 1 and 2 were lost or broken, as the case may be, the name and address of the prescriber, the name and address of the patient and the purpose for which the prescription was ordered; provided, however, that the registered pharmacists or assistant registered pharmacists who deliver or sell any instruments specified in Sections 1 and 2 shall send a copy of such affidavit to the Department of Law Enforcement by the 15th of the month following the month in which such instruments were delivered or sold. Such written or oral prescriptions when reduced to writing for instruments specified in Sections 1 and 2 shall contain the date of such prescription, the name and address of the prescriber, the name and address of the patient, the purpose for which the prescription is ordered, the date when dispensed and by whom dispensed.

Provided, however, that a licensed physician or other allied medical practitioner, authorized by the laws of the State of Illinois to prescribe or administer controlled substances or cannabis to humans or animals, may authorize any person or the owner of any animal, to purchase and have in his possession any of the instruments specified in Sections 1 and 2, which may be sold to him without a specific written or oral prescription or order, by any person authorized by the laws of the State of Illinois to sell and dispense controlled substances or cannabis, if such authorization is in the form of a certificate giving the name and address of such licensed physician or other allied medical practitioner, the name, address and signature of the person, or of the owner of the animal, so authorized, the purpose or reason of such authorization, and the date of such certificate and in that event, no other prescription, writing or record shall be required to authorize the possession or sale of such instruments.

APPENDIX 14

Public Act 77-772
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 38, Sections 8-2, 36-1, 37-1 and 37-4)

Amends the Criminal Code of 1961 by Substituting Uniform Controlled Substances Act for Uniform Narcotic Drug Act, and controlled substances for narcotic drugs so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 8-2, 36-1, 37-1 and 37-4 of the "Criminal Code of 1961", approved July 28, 1961, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 8-2, 36-1, 37-1 and 37-4 of the "Criminal Code of 1961", approved July 28, 1961, as amended, are amended to read as follows:

Sec. 8-2. Conspiracy.) (a) Elements of the offense. A person commits conspiracy when, with intent that an offense be committed, he agrees with another to the commission of that offense. No person may be convicted of conspiracy to commit an offense unless an act in furtherance of such agreement is alleged and proved to have been committed by him or by co-conspirator.

(b) Co-conspirators.

It shall not be a defense to conspiracy that the person or persons with whom the accused is alleged to have conspired:

(1) Has not been prosecuted or convicted, or
(2) Has been convicted of a different offense, or
(3) Is not amenable to justice, or
(4) Has been acquitted, or
(5) Lacked the capacity to commit an offense.

(c) Penalty.

A person convicted of conspiracy may be fined or imprisoned or both not to exceed the maximum provided for the offense which is the object of the conspiracy, except that if the object is an offense prohibited by Sections 11-15, 11-16, 11-17, 11-19, 24-1 (a) (1), 24-(1) (a) (7), 28-1, 28-3 and 28-4 of the "Criminal Code of 1961", approved July 28, 1961, as amended or prohibited by Sections 401, 402, 403, 404, 406(b) or 407 of the "Illinois Controlled Substances Act", enacted by the 77th General Assembly or an inchoate offense related to any of the aforesaid principal offenses the person convicted may be imprisoned not to exceed 10 years: Provided, however, that no penalty for conspiracy to commit treason, murder, or aggravated kidnapping shall exceed imprisonment for 20 years, and no penalty for conspiracy to commit any offense other than those specified in this subsection shall exceed imprisonment for 5 years.

Sec. 36-1. Seizure.) Any vessel, vehicle or aircraft used with the knowledge and consent of the owner in the commision of, or in the attempt to commit as defined in Section 8-4 of this Code, an offense prohibited by (a) Section 9-1, 10-2, 18-2, 19-1, 19-2, 20-1, 20-2, or 28-1 of this Code as now or hereafter amended; (b) Section *401,* 402, 403, 404, 406 (b) or 407 of the "Illinois Controlled Substances Act", or Section 4, 5 or 9 of the Cannabis Control Act" enacted by the 77th General Assembly as now or hereafter amended; (c) Section 21, 22, 23, 24 or 26 of the "Cigarette Tax Act", approved June 2, 1941, as now or hereafter amended, if the vessel, vehicle or aircraft contains more than 10 cartons of such cigarettes; or (d) Section 28, 29 or 30 of the "Cigarette Use Tax Act", approved July 11, 1951, as now or hereafter amended, if the vessel, vehicle or aircraft contains more than 10 cartons of such cigarettes; may be seized and delivered forthwith to the sheriff of the county of seizure. Within 15 days after such delivery the sheriff shall give notice of seizure to each person according to the following method: Upon each such person whose right, title or interest is of record in the office of the Secretary of State, the Director of the Department of Aeronautics, the Administrator of the Federal Aviation Agency, the Director of the Department of Public Works and Buildings, or any other Department of this State, or any other state of the United States if such vessel, vehicle or aircraft is required to be so registered, as the case may be, by mailing a copy of the notice by certified mail to the address as given upon the records of the Secretary of State, the Departmentt of Aeronautics, Department of Public Works and Buildings or any other Department of this State or the United States if such vessel, vehicle or aircraft is required to be so registered. Within that 15 day period the sheriff shall also notify the State's Attorney of the county of seizure about the seizure.

Sec. 37-1. Maintaining Public Nuisance.) Any building used in the commission of offenses prohibited by Sections 9-1, 10-1, 10-2, 11-14, 11-15, 11-16, 11-17, 16-1, 20-2, 23-1, 23-1 (a) (1), 24-1 (a) (7), 24-3, 28-1, 28-3, 31-5 or 39A-1 of the "Criminal Code of 1961", approved July 28, 1961, as heretofore and hereafter amended, or prohibited by the Illinois Controlled Substances Act", or the "Cannabis Control Act" enacted by the 77th General Assembly, as heretofore and hereafter amended, or used in the commission of an inchoate offense relative to any of the aforesaid principal offenses is a public nuisance. A person convicted of knowingly maintaining such a public nuisance shall be fined not to exceed $1,000 or imprisoned in a penal institution other than the penitentiary not to exceed one year or both. For each subsequent offense under this Section such person shall be fined not to exceed $3,000 or imprisoned in a penal institution other than the penitentiary not to exceed one year or in the penitentiary from one to 5 years, or both fined and imprisoned.

Sec. 37-4. Abatement of Nuisance.) The Attorney General of this State or the State's Attorney of the county of nuisance may commence an action to abate a public nuisance as described in Section 37-1 of this Act, in the name of the People of the State of Illinois, in any court of competent jurisdiction. Upon being satisfied by affidavits or other sworn evidence that an alleged public nuisance exists, the court may without notice or bond issue a temporary injunction to enjoin any defendant from maintaining such nuisance and may issue an order restraining any defendant from removing or interfering with all property used in connection with the public nuisance. If during the proceedings and hearings upon the merits, which shall be in the manner of "An Act in relation to places used for the purpose of using, keeping or selling controlled substances or cannabis", approved July 5, 1957, the existence of the nuisance is established, and it is established that such nuisance was maintained with the intentional, knowing, reckless or negligent permission of the owner or the agent of the owner managing the building, the court shall enter a decree restraining all persons from maintaining or permitting such nuisance and from using the building for a period of one year thereafter, except that an owner, lessee or other occupant thereof may use such place if the owner shall give bond with sufficient security or surety approved by the court, in an amount between $1,000 and $5,000 inclusive, payable to the People of the State of Illinois, and including a condition that no offense specified in Section 37-1 of this Act shall be committed at, in or upon the property described and a condition that the principal obligor and surety assume responsibility for any fine, costs or damages resulting from such an offense thereafter.

APPENDIX 15

Public Act 77-773
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 127 Section 63b108b.4)

Amends the Personnel Code (rejection of candidates or eligibles) by substituting controlled substances for narcotics so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Section 8b.4 of the "Personnel Code" approved July 18, 1955, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assmbly:

Section 1. Section 8b.4 of the "Personnel Code" approved July 18, 1955, as amended, is amended to read as follows:

Sec. 8b.4. For the rejection of candidates or eligibles who fail to comply with reasonable previously specified job requirements of the Director in regard to such factors as age, physical and psychological condition, training and experience; who have been guilty of infamous or disgraceful conduct; who are addicted to alcohol to excess or to controlled substances or uses cannabis; or who have attempted any deception or fraud in connection with an examination.

APPENDIX 16

Public Act 77-775
77th General Assembly
Effective August 16, 1971

SYNOPSIS: (Chapter 91½, Section 30.1 et seq.)

Amends the Community Mental Health Act by substituting controlled substance addicts or addiction for drug addicts or addiction so as to conform to the Illinois Controlled Substances Act introduced at the 77th General Assembly.

AN ACT to amend Sections 2, 3a, 4, 5, 6, 10 and 11 of the "Community Mental Health Act", approved August 31, 1967, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 2, 3a, 4, 5, 6, 10 and 11 of the "Community Mental Health Act," approved August 31, 1967, as amended, are amended to read as follows:

Sec. 2. Any county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district or any combination thereof, in consultation with and being advised by the Department of Mental Health, shall have the power to construct, repair, operate, maintain and regulate community mental health facilities to provide mental health services, including services for the alcoholic, the controlled substance addicted users of cannabis and for the mentally retarded, for residents thereof and/or to contract therefor with any private or public entity which provides such facilities and services, either in or without such county, city, village, incorporated town, township, public health district, county health department, multiple-county health department, school district or any combination thereof.

Sec. 3a. Every governmental unit authorized to levy an annual tax under any of the provisions of this Act shall, before it may levy such tax, establish a 7 member community mental health board who shall administer this Act. Such board shall be appointed by the chairman of the governing body of a county, the mayor of a city, the president of a village, the president of an incorporated town, or the supervisor of a township, as the case may be, with the advice and consent of the governing body of such county, city, village, incorporated town or the town board of auditors and town clerk of any township. Membership of the community mental health board shall as nearly as possible be representative of interested groups of the community such as local health departments, medical societies, local welfare boards, hospital boards, school boards, lay associations concerned with mental health or alcoholism, controlled substances addiction or use of cannabis or mental retardation, as well as labor, business and civic groups or the general public.

Sec. 4. In order to provide the necessary funds or to supplement existing funds for such community mental health facilities and services, including facilities and services, for the alcoholic, the controlled substances addicted users of cannabis and the mentally retarded, the governing body of any governmental unit, subject to the provisions of Section 5, may levy an annual tax of not to exceed .1% upon all of the taxable property in such governmental unit at the full, fair cash value thereof, as equalized or assessed by the Department of Revenue. Such tax shall be levied and collected in the same manner as other governmental unit taxes, but shall not be included in any limitation otherwise prescribed as to the rate or amount of governmental unit taxes, but shall be in addition thereto and in excess thereof.

When collected, such tax shall be paid into a special fund in the governmental unit treasury to be designated as the "Community Mental Health Fund" and shall be used only for the purposes specified in this Act. Nothing contained herein shall in any way preclude the use of other funds available for such purposes under any existing statute relating to such governmental unit.

In any city, village, incorporated town, or township which levies a tax for the purpose of providing community mental health facilities and services and part or all of such city, village, incorporated town, or township is in a county or township, as the case may be, which levies a tax to provide community mental health facilities and services under the provisions of this Act, such county or township, as the case may be, shall pay to such city, village, incorporated town, or township, as the case may be, the entire amount collected from taxes under this Section on property subject to a tax which any city, village, incorporated town, or township thereof levies to provide community mental health facilities and services.

Whenever any city, village, incorporated town, or township receives any payments from a county or township as provided above, such city, village, incorporated town, or township shall reduce and abate from the tax levied by the authority of this Section a rate which would produce an amount equal to the amount received from such county or township.

Sec. 5. When the governing body of a governmental unit passes a resolution as provided in Section 4 asking that an annual tax may be levied for the purpose of providing such mental health facilities and services, including facilities and services for the alcoholic, the controlled substances addicted users of cannabis and the mentally retarded, in the community and so instructs the clerk of the governmental unit such clerk shall, in the next legal notice of a regular general election in the governmental unit or at least 20 days before a special election called for the purpose by the governing body of the governmental unit give notice that at such election every elector may vote for or against the levy of a tax for the purpose of providing community mental health facilities and services and shall make provision for voting upon the propositions at such election. The ballot to be used for the submission of the proposition at such election shall be in substantially the following form:

Shall ..... (governmental unit), levy an annual tax of not to exceed .1% for the purpose of providing community mental health facilities and services?	YES NO

If a majority of all the votes cast upon the proposition are for the levy of such tax, the governmental body of such governmental unit may thereafter annually levy such tax. Thereafter the governing body shall in the annual appropriation bill appropriate from such funds such sum or sums of money as may be deemed necessary, based upon recommendations by the community mental health board to defray necessary expenses and liabilities in providing for such community mental health facilities and services.

Sec. 6. Whenever the governing body of any governmental unit has not provided the community mental health facilities and services provided in Section 2 and levied the tax provided in Section 4 and a petition signed by electors of the governmental unit equal in number to 10% of the total votes cast at the last preceding general governmental unit election is presented to the clerk of the governmental unit requesting the establishment and maintenance of such community mental health facilities and services, including facilities and services for the alcoholic, the controlled substances addicted users of cannabis and the mentally retarded, for residents thereof and the levy of such an annual tax therefor, the governing body of the governmental unit, subject to the provisions of Section 7, shall establish and maintain such community mental health facilities and services and shall levy such an annual tax of not to exceed .1% upon all of the taxable property in such governmental unit at the full, fair cash value thereof, as equalized or assessed by the Department of Revenue. Such tax shall be levied and collected in the same manner as other governmental unit taxes, but shall not be included in any limitation otherwise prescribed as to the rate or amount of governmental unit taxes, but shall be in addition thereto and in excess thereof.

When collected, such tax shall be paid into a special fund in the governmental unit treasury to be designated as the "Community Mental Health Fund" and shall be used only for the purposes specified in this Act. Nothing contained herein shall in any way preclude the use of other funds available for such purposes under any existing statute relating to such governmental unit.

In any city, village, incorporated town, or township which levies a tax for the purpose of providing community mental health facilities and services and part or all of such city, village, incorporated town, or township is in a county or township, as the case may be, which levies a tax to provide community mental health facilities and services under the provisions of this Act, such county or township, as the case may be, shall pay to such city, village, incorporated town, or township, as the case may be, the entire amount collected from taxes under this Section on property subject to a tax which any city, village, incorporated town, or township thereof levies to provide community mental health facilities and services.

Whenever any city, village, incorporated town, or township receives any payments from a county or township as provided above, such city, village, incorporated town, or township shall reduce and abate from the tax levied by the authority of this Section a rate which would produce an amount equal to the amount received from such county or township.

Sec. 10. Whenever the governing body of a governmental unit by resolution determines that it is necesary to issue bonds of the governmental unit to enable it to provide buildings for or to make permanent improvements in the community mental health facilities including facilities for the alcoholic, the controlled substances addicted users

of cannabis and the mentally retarded, the governing body shall so instruct the clerk of the governmental unit. Thereupon, such clerk shall, in the next legal notice of a regular election within the governmental unit or at least 20 days before a special election called for the purpose by the governing body of the governmental unit, give notice that at such election every elector may vote for or against the issuance of such bonds, and shall make provision for voting upon the proposition at such election.

Sec. 11. The ballot to be used at any election held pursuant to Section 10 shall be in substantially the following form:

OFFICIAL BALLOT

Instructions to voters: To cast a ballot in favor of the proposition submitted upon this ballot, place an (x) mark in the square opposite the word "Yes"; to vote against the proposition submitted upon this ballot, place an (x) mark opposite the word "No".

Shall the ..... (governmental unit) issue bonds to the amount of ..... dollars for the purpose of enabling the governmental unit to ..... (purpose to be stated, which shall be either to provide buildings for or to make permanent improvements in the community mental health facilities including facilities for the alcoholic, the controlled substances addicted or the mentally retarded)?	YES NO

In case a majority of the votes cast upon the propositions shall be in favor of the issuance of such bonds; the governing body of the governmental unit shall issue the bonds of the governmental unit not exceeding the amount authorized at the election. Such bonds shall become due not more than 20 years after their date, shall be in denominations of $100 or any multiple thereof, and shall bear interest, evidenced by coupons, at a rate not exceeding 5% per annum, payable semi-annually, as shall be determined by the governing body.

APPENDIX 17

SONGS REFERRING TO DRUGS

WITH A LITTLE HELP FROM MY FRIENDS*

Words and music by John Lennon and Paul McCartney
(of the Beatles)

Recorded by Sergio Mendes & Brash 66
on A & M Records

What would you do if I sang out of tune
Would you stand up and walk on on me
Lend me your ears and I'll sing you a song
And I'll try not to sing out of key
Oh I get by with a little help from my friends

Mm, I get high with a little help from my friends
Mm I'm gonna try with a little help from my friends
Do you need anybody?
I just need somebody to love
Could it be anybody? I want somebody to love

With a little help from my friends
M'm I' gonna try with a little help from my friends
Oh I get high with a little help from my friends
Yes, I get by with a little help from my friends.

** Implying that those using narcotics, marihuana, or psychedelics share these drugs with one another.*

PUFF THE MAGIC DRAGON*

Words and music by Peter Yarrow and Leonard Lipton

Recorded by PETER, PAUL & MARY on
Warner Bros. Records

Puff, the magic dragon lived by the sea
And frolicked in the autumn mist
In a land called HonahLee.

Little Jackie Paper loved that rascal PUFF

And brought him strings and sealing wax and other fancy stuff

Oh, PUFF the magic dragon lived by the sea
And frolicked in the autumn mist.
In a land called HonahLee,

PUFF, the magic dragon lived by the sea
And frolicked in the autumn mist in a land called HonahLee

Together they would travel on a boat with billowed sail
Jackie kept a lookout perched on Puff's gigantic tail
Noble kings and princes would bow when-eer they came
Pirate ships would lower their flag when PUFF roared out his name.
Oh! land called HonahLee

Second Verse

A dragon lives forever but not so little boys
Painted wings and giant rings make way for other toys.
One grey night it happened
Jackie Paper came no more.
And PUFF that mighty dragon, he ceased his fearless roar.
Oh! land called HonahLee

Third Verse

His head was bent in sorrow — green scales fell like rain
PUFF no longer went to Oaly along the cherry lane.
Without his life long friend.
PUFF could not be brave.
So PUFF that mighty dragon, sadly slipped into his cave.
Oh! land called HonahLee.

* *Smoking marihuana and hashish.*

YELLOW SUBMARINE*

Words and music by John Lennon and Paul McCartney
(The Beatles)

Recorded by The Beatles, on Apple Records

In the town where I was born
Lived a man who sailed to sea
And he told us of his life
In the land of submarines

So we sailed up to the sun
Till we found the sea of green
And we lived beneath the waves
In our yellow submarine

We all live in a yellow submarine
Yellow submarine, yellow submarine
We all live in a yellow submarine
Yellow submarine, yellow submarine

And our friends are all on board
Many more of them live next door
And the band begins to play

Second Verse

As we live a life of ease
Every one of us has all we need
Sky of Blue and sea of green in our
Yellow submarine.

* *Street jargon for yellow, barbiturate capsules.*

LUCY IN THE SKY WITH DIAMONDS*

Words and music by John Lennon and Paul McCartney
(The Beatles)

Recorded by The Beatles, on Apple Records

Picture yourself in a boat on a river
With tangerine trees and marmalade skies.
Somebody calls you, you answer quite slowly

A girl with kaleidoscope eyes
Celophane flowers of yellow and green, towering
Over our head
Look for the girl with the sun in her eyes
And she's gone.
Lucy in the sky with diamonds. Ah Ah

Second Verse

Follow her down to a bridge
By a fountain where rocking horse people eat
Marshamallow pies.
Evey one smiles as you drift past the flowers
That grow so incredibly high.

Newspaper tax is appear on the shore
Waiting to take you away. Climb in the back
With your head in the clouds and you're gone.
Lucy in the sky with diamonds. Ah Ah

Third Verse

Picture yourself on a train
In a station with plasticine porters
With looking glass ties.
Suddenly someone is there at the turnstile
The girl with kaleidoscope eyes.

Celophane flowers of yellow and green, towering
Over your head.
Look for the girl with the sun in her eyes
And she's gone.
Lucy In the Sky with Diamonds. Ah. Ah.

* *The initial letters in the title form the word LSD. The song depicts the pleasures of using LSD.*

A WHITER SHADE OF PALE*

Words and music by Keith Reid and Gary Brooker

Recorded by Procol Harum group, on RCA Records

We skipped the light fan dango
And turned cartwheels cross the floor
I was feeling kind of sea-sick
But the crow called out for more
The room was humming harder
As the ceiling flew away

When we called out for another drink
The waiter brought a tray
And so it was that later
As the miller told his tale
That her face at first just ghostly
Turned a whiter shade of pale

Second Verse

She said "There is no reason
And the truth is plain to see"
But I wandered through my playing cards
And would not let her be
One of sixteen vestal virgins
Who were leaving for the coast

And although my eyes were open
They might just have well been closed.

* *Mind bending characteristics of the psychedelics.*

HI-DE-HO*
(That Old Sweet Roll)

Words and music by Gerry Coffin and Carole King

Recorded by BLOOD, SWEAT & TEARS,
on Columbia Records

HIDEHO, HIDEHI, *Gonna get me a piece of the sky,*
Gonna find me some of that old sweet roll
Singin Hidehi Hideho.

I been down so low bottom looked like up
Once I thought that second saved was enough to fill my cup
Now I proffered all I had,
But it aint' no way to live
Bein taken by the ones who got the least amount to give

Hideho, hidehi, Gonna get me a piece of the sky
Gonna find me some of that old sweet roll
Singin Hidehi Hideho

Second Verse

Once I met the devil and he was might slick
Tempted me with worldly goods and said
"You can have your pick."
But when he laid that paper on me
And showed me where to sign
I said "Thank you very kindly,
But I'm in too great a need of mine."

* *Joys of smoking marihuana.*

LET'S GO GET STONED*

Words and music by Valerie Simpson,
Nicholas Ashford, Josephine Armsted

Recorded by Joe Cocker, on A & M Records

Let's go get stoned. Let's go get stoned.
Let's go get stoned.
When your baby won't let you in
Got a few pennies, a bottle of gin

Just call your buddy on the telephone
Let's go get stoned.

It ain't no harm to have a little taste
But don't blow your cool
and start messing up the place
It ain't no harm, to take a little nip
But make sure you don't fall down, and bust your lip
Let's go get stoned.

Second Verse

When you work so hard all the day long
And everything you do seems to go wrong
Just drop by my place on your way home
Let's go get stoned.

* *Lyrics have a double meaning, referring to alcohol but also to drugs.*

WHITE RABBIT*

"Psychedelic Stomp"
Words and Music by Grace Slick

Recorded by the Jefferson Airplane, on
RCA Victor Records

One *pill* makes you larger
And one *pill* makes you small
And the ones that mother gives you
Don't do anything at all

Go ask Alice
when she's ten feet all
And if — When men on chessboard get up
And tell you where to go

And you've just had *some kind of mushroom*
And your mind is moving low
Go ask Alice, I think she'll know.

When logic and proportion have fallen sloppy dead
And the *White Knight* is talking backwards
and the *Red Queen's* lost her head
Remember what the Dormouse said.
Feed your head, feed your head

Second Verse

You go chasing rabbits
And you know you're going to fall.
Tell em all who got a smoking caterpillar
Has given you the call. Call Alice.
When she was just small

* *Extolling the kicks provided by LSD and other psychedelics.*

APPENDIX 18

AUTHORITIES CONSULTED

During the course of our public hearings in Chicago and Springfield, Illinois we received testimony from witnesses occupying official positions at different levels of government in this State and elsewhere in the United States. We also heard from other persons possessing expertise in various phases of the drug abuse problem.

In our field trips to New York City, Washington, D. C., Los Angeles and San Francisco we obtained the views of additional drug abuse experts in both categories.

It was obviously not possible to see and talk to all the experts in this vast and complicated field of drug abuse. Therefore, in our efforts to obtain as much input as possible, and in consideration of our limited resources, we solicited the written observations of some of these individuals.

Following is a list of all the authorities consulted in the above mentioned classifications.

Dr. Harold A. Abramson
South Oaks Research Foundation, Inc., Sunrise Highway, Amityville, Long Island, N. Y. 11701.

Daniel J. Addario
Special Agent in Charge, U. S. Bureau of Narcotics and Dangerous Drugs, 450 Golden Gate Avenue, San Francisco, California 94102.

Eduardo Aguirre
Director, League of United Citizens to Help Addicts, 920 South Atlantic Boulevard, East Los Angeles, California.

Dr. Robert W. Baird
860 Fifth Avenue, New York, New York 10021.

Dr. John C. Ball
Addiction Sciences Center, Temple University, Henry Avenue & Abbotsford Road, Philadelphia, Pennsylvania 19129.

Frank A. Bartimo
Assistant General Counsel, Department of Defense, Pentagon, Room 3E-963, Washington, D. C.

William Bauer
U. S. Attorney, Federal Building, 219 South Dearborn Street, Chicago, Illinois 60604.

H. Bruce Baumeister
Past President, Association of Juvenile Court Lawyers, 433 South Beverly Drive, Suite 105, Beverly Hills, California 90212.

Joseph M. Benforado
University Health Service, University of Wisconsin, Madison, Wisconsin.

Dr. I. F. Bennett
Lilly Laboratory for Clinical Research, Marton County General Hospital, Indianapolis, Indiana 46202.

Peter B. Bensinger
Director, Illinois Department of Corrections, 160 North LaSalle Street, Chicago, Illinois 60601.

Dr. Edward R. Bloomquist
Associate Clinical Professor of Surgery, School of Medicine, University of California, Los Angeles, California.

Dr. Richard H. Blum
Program Director, Institute of Public Policy Analysis, Stanford University, 584 Mayfield, Stanford, California 94305.

David Blumenfeld
Pharmacy Coordinator, Illinois Department of Registration and Education, 160 North LaSalle Street, Chicago, Illinois 60601.

Robert Bonneville
Captain, Police Department, Glencoe, Illinois.

Joseph A. Bou-Sliman
Director, Central States Institute of Addiction, 122 South DesPlaines Street, Chicago, Illinois 60606.

Edward C. Boyle
Salvation Army Family Service Center, 916 Francisco Street, Los Angeles, California.

Dr. Henry Brill
New York State Department of Mental Hygiene, Pilgrim State Hospital, Box 22, West Brentwood, Long Island, New York.

Bernard Brown
Detective, Narcotic Unit, Police Department, 1121 South State Street, Chicago, Illinois 60605.

Herbert D. Brown
Director, Department of Law Enforcement, 103 State Armory, Springfield, Illinois 62706.

Dr. Henry B. Bruyn
Director of Student Health, University of California, Berkeley, California 94720.

Joseph P. Busch, Jr.
District Attorney, Los Angeles County, 211 West Temple Street, Los Angeles, California 90012.

William Cahn
District Attorney, County Courthouse, Nassau County, New York.

Dr. Dale C. Cameron
Chief, Drug Dependence, World Health Organization Geneva, Switzerland 1211.

Dr. P. A. Carone
South Oaks Research Foundation, Inc., Sunrise Highway, Amityville, Long Island, New York 11701.

Daniel P. Casey
Regional Director, U. S. Bureau of Narcotics and Dangerous Drugs, 1340 West 6th Street, Los Angeles, California.

Dr. Carl D. Chambers
West Philadelphia Community Mental Health Consortium, Philadelphia, Pennsylvania.

Carl Charnett
Director of Dynamics, Gateway House, 4800 South Ellis, Chicago, Illinois 60615.

Richard G. Christensen
Director, Creative Life Foundation, P. O. Box 15390, Seattle, Washington 98115.

Walter Collier
Director of Research, Daytop Village, 184 Fifth Aveneu, New York, N. Y.

Thomas Coulter
Chief Executive Officer, Chicago Association of Commerce and Industry, 130 South Michigan Avenue, Chicago, Illinois 60603.

Roy Dankman
President, Association of Juvenile Court Lawyers, 433 South Beverly Drive, Suite 105, Beverly Hills, California 90212.

Daniel D'Aquila
Chief of Police, Downers Grove, Illinois.

Edward M. Davis
Chief of Police, Parker Center, 150 North Los Angeles Street, Los Angeles, California 90012.

John Paul Davis
Legal Assistant to the Chancellor, Southern Illinois University, 400 West Union, Edwardsville, Illinois 62025.

Charles Devlin
Director, Rehabilitation Services, Daytop Village, 184 Fifth Avenue, New York, New York.

Meyer Diskland
Commissioner, New York Narcotic Addiction Control Commission, 1855 Broadway, New York, New York 10023.

Phil Doherty
Ex-addict, Gateway House, 4800 South Ellis, Chicago, Illinois 60615.

Dr. Vincent P. Dole
The Rockefeller University, New York, New York 10021.

Osie Dompier
Special Agent in Charge (retired), U. S. Bureau of Customs, Chicago, Illinois.

Dr. Nathan B. Eddy
Chairman, National Research Council, 2101 Constitution Avenue, Washington, D. C. 20418.

Richard J. Elrod
Sheriff, Civic Center, Chicago, Illinois.

John G. Evans
Regional Director, U. S. Bureau of Narcotics and Dangerous Drugs, 205 West Wacker Drive, Chicago, Illinois 60606.

Dr. Seymour M. Farber
Dean, Continuing Education in Health Science, University Of California, San Francisco, California.

Donald K. Fletcher
Manager, Distribution Protection, Smith, Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

Stan J. Friedman
Assistant Director, Beth Israel Medical Center, 245 East 17th Street, New York, New York.

Louis Fulgaro
Sgt., Narcotic Unit, Police Department, Downers Grove, Illinois.

Dr. George Gay
Drug Detoxification Center, Haight-Ashbury Clinic, 558 Clayton Street, San Francisco, California.

Gerald W. Getty
Public Defender, Criminal Courts Building, Suite 301, 2600 South California Avenue, Chicago, Illinois 60608.

Dr. Frederick B. Glaser
Addiction Sciences Center, Temple University, Henry Avenue & Abbottsford Road, Philadelphia, Pennsylvania 19129.

Benjamin Goldman
Director, Bayview Rehabilitation Center, 550 West 20th Street, New York, New York.

Dr. Harvey Gollance
Associate Director, Beth Israel Medical Center, 245 East 17th Street, New York, New York.

Dr. Charles W. Gorodetzky
NIMH Addiction Research Center, Lexington, Kentucky.

Tawney Guyon
Ex-addict, Gateway House, 4800 South Ellis Street, Chicago, Illinois 60615.

Eugene Haislip
Attorney, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. W., Washington, D. C. 20537.

Edward Hammock
Executive Director, Daytop Village, 184 Fifth Avenue, New York, New York 10010.

James G. Hanlon
Vice President, Manager of Public Relations and Advertising, WGN Continental Broadcasting Company, 2501 Bradley Place, Chicago, Illinois 60618.

Edward V. Hanrahan
State's Attorney, Criminal Courts Building, 2600 South California Avenue, Chicago, Illinois 60608.

John F. Ingersoll
Director, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. W., Washington, D. C. 20537.

Arthur Inman
Assistant State's Attorney, Sangamon County, County Building, Springfield, Illinois 62701.

Dr. Harris Isbell
University of Kentucky Medical Center, Lexington, Kentucky.

Dr. Richard P. Issel
5307 West Agatite, Chicago, Illinois 60630.

Dr. Jerome H. Jaffe
Former Director of the Illinois Drug Abuse Program, 57th Street & South Lake Shore Drive, Chicago, Illinois 60637.

Dr. Donald R. Jasinski
NIMH Addiction Research Center, Lexington, Kentucky.

Dr. Hardin B. Jones
Professor of Physiology and Medical Physics, Donner Laboratory, University of California, Berkeley, California 94720.

Dr. Seymour Joseph
Commissioner, New York State Narcotic Addiction Control Commission, 1855 Broadway, New York, New York 10023.

Charles King
Commissioner, New York State Narcotic Addiction Control Commission, 1855 Broadway, New York, New York 10023.

Roy Kinsey
Attorney Advisor, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. W., Washington, D. C. 20537.

Mildred Klein
Narcotics Consultant, Community Relations Division, Los Angeles County Probation Department, 433 South Vermont, Los Angeles, California.

Richard Kleindienst
U. S. Attorney General, Department of Justice, Washington, D. C.

Dr. Robert J. Kokoski
Director, Drug Abuse Laboratory, Friends of Psychiatric Research, Inc., 52 Wade Avenue, Baltimore, Maryland 21228.

Dr. L. W. Krinsky
South Oaks Research Foundation, Inc., Sunrise Highway, Amityville, Long Island, New York 11701

Dr. Granville W. Larimore
Florida Regional Medical Program, 1 Davis Blvd., Tampa, Florida.

Herbert Lee
Inspector, Police Department, Hall of Justice, 850 Bryant Street, San Francisco, California 91343.

Dr. J. Joseph Levin
Ravenswood Clinic, 1931 West Wilson, Chicago, Illinois 60640.

Edward Lichtman
Administrative Assistant, Beth Israel Medical Center, 245 East 17th Street, New York, New York.

Prof. Alfred R. Lindesmith
Department of Sociology, Ballantine Hall, Bloomington, Indiana 47401.

Arthur Linkletter
29229 Heathercliff Road, Pt. Dume, Malibu, California 90265.

Dr. Donald Bruce Louria
Chairman, New York State Council on Drug Addiction, 100 Bergen Street, Building No. 12, Room 1204, Newark, New Jersey.

John Luce
Continuing Education in Health Sciences, University of California, San Francisco, California.

Dr. Vincent de Paul Lynch
St. John's University, College of Pharmacy, Grand Central and Utopia Parkways, Jamaica, New York 10032.

William Mahoney
Lieutenant, Narcotic Unit, Police Department, 1121 South State Street, Chicago, Illinois 60605.

D. L. McKinney
Sgt., Criminal Investigation Section, Illinois State Police, 220 Iles Park Place, Springfield, Illinois 62703.

Gordon McLean
Executive Director, Drug Abuse Information Service, 1190 Lincoln Avenue, Suite 6, San Jose, California 95125.

John Merlo
Representative, Illinois General Assembly, Chicago, Illinois.

Donald Miller
Chief Counsel, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. W., Washington, D. C. 20537.

Michael Morrell
Attorney Advisor, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. Y., Washington D. C. 20537.

Alfred Nelder
Chief of Police, Hall of Justice, 850 Bryant Street, San Francisco, California 94103.

Dr. Marie Nyswander
960 Park Avenue, New York, New York.

William C. O'Donnell
Vice President, Columbia Broadcasting System, WBBM Radio, 630 North McClurg, Chicago, Illinois.

Clyde W. Oliver
Captain, Chief, Criminal Investigation Section, Illinois State Police, 220 Iles Park Place, Springfield, Illinois 62703.

William D. M. Paton
University Department of Pharmacology, South Parks Road, Oxford, Oxi, 3 Q.T., England.

Peter J. Pitchess
Sheriff, Los Angeles County, Room 206, Hall of Justice, 211 West Temple Street, Los Angeles, California 90012.

Dr. Harvey Powelson
Chief, Psychiatric Clinic, Cowell Memorial Hospital, University of California, Berkeley, California 94720.

Dr. Herbert A. Raskin
20100 Civic Center Drive, Detroit, Michigan.

Leland H. Rayson
Representative, Illinois General Assembly, Tinley Park, Illinois.

Charles Reese
Ex-addict, Gateway House, 4800 South Ellis, Chicago, Illinois 60615.

Ellis E. Reid
President, Cook County Bar Association, 123 West Madison Street, Chicago, Illinois 60602.

Cynthia Rose
Ex-addict, Gateway House, 4800 South Ellis, Chicago, Illinois 60615.

Dr. Jordan Scher
Director, Chicago Psychiatric Foundation and Onto-analytic Institute, 8 South Michigan Avenue, Chicago, Illinois 60603.

Edward T. Scholl
Alderman, 6021 Northwest Highway, Chicago, Illinois

Dr. Charles R. Schuster
Billings Hospital, 950 East 59th Street, Chicago, Illinois 60637.

Dr. Maurice H. Seevers
Department of Pharmacology, M 6322 Medical Science Building, University of Michigan, Ann Arbor, Michigan 48104.

Professor Arthur H. Sherry
358 Boalt Hall, School of Law, University of California, Berkeley, California 94720.

George Simms
Assistant Deputy Superintendent, Chicago Police Department, 1121 South State Street, Chicago, Illinois 60605.

Dr. Joseph H. Skom
707 North Fairbanks Court, Chicago, Illinois 60611.

Dr. Henry A. Smith
Director, Phoenix Academy, P. O. Box 307, Wheaton, Illinois.

Joanna Smith
Assistant Director, Phoenix Academy, P. O. Box 307, Wheaton, Illinois.

Warren K. Smoot
Assistant Attorney General, 188 West Randolph Street, Room 2200, Chicago, Illinois 60601.

Thomas P. Sullivan
Jenner & Block, 135 South LaSalle Street, Chicago, Illinois 60603.

Fred G. Suria, Jr.
Presiding Judge, Narcotics Court, 2600 South California Avenue, Chicago, Illinois 60608.

Andrew C. Tartaglino
Assistant Director, U. S. Bureau of Narcotics and Dangerous Drugs, 1405 Eye Street, N. W., Washington, D. C. 20537.

Gene Taylor
General Manager, WLS Radio, 360 North Michigan Avenue, Chicago, Illinois 60601.

Arthur A. Telcser
Representative, Illinois General Assembly, Chicago, Illinois.

Dr. Andrew J. Toman
Corner of Cook County, Civic Center, Chicago, Illinois.

Dr. J. Thomas Ungerleider
601 Wilshire, Los Angeles, California.

Dr. Richard I. H. Wang
Chief, Clinical Pharmacology Service, Medical College of Wisconsin, Wood Veterans Administration Hospital, West National Avenue at 54th Street, Wood, Wisconsin 53193.

Mitchel Ware
Superintendent, Illinois Bureau of Investigation, 839 West Exchange Avenue, Chicago, Illinois 60609.

Erwin Weingartner
Director, Student Services, New Trier East High School, Winnetka, Illinois.

Kenneth R. Wendt
Judge of Cook County, Civic Center, Chicago, Illinois.

Dr. Vernon E. Wilson
Administrator, Health Services & Mental Health Administration, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

Dr. Robert L. Wolen
Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis, Indiana.

Harlington Wood, Jr.
Associate Deputy Attorney General, U. S. Department of Justice, Washington, D. C.

Roland W. Wood
Superintendent, California Rehabilitation Center, Department of Corrections, P. O. Box 841, Corona, California 91720.

George Zitterell
Department of Pharmacology, St. John's University, Grand Central and Utopia Parkways, Jamaica, New York 10032.

BIBLIOGRAPHY

For easier reference purposes we have divided this bibliography into the following sections:

1. Drug Dependence and Narcotic Drugs
2. Marihuana
3. Stimulants and Depressants
4. Hallucinogens
5. Other Articles in Medical and Scientific Journals
6. Pamphlets
7. Film Distributors

Sections 1 through 4 include a select list of books, and articles which have appeared in medical, scientific and other professional magazines. We have purposely limited fiction-type books to those few which we believe would contribute to a serious study of the drug abuse problem.

Persons wishing to obtain any of these references should not communicate with this Commission but should consult their metropolitan libraries or the publishers. Also, inquiries concerning films should be directed to the distributors included in the final section.

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12. *Marihuana Practices in the Haight-Ashbury Subculture*
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561 Hillgrove Avenue, La Grange, Illinois 60525.
Association Films, Inc.
600 Grand Avenue, Ridgefield, New Jersey 07657.
Bailey Films, Inc.
6509 De Longpre Avenue, Hollywood, California 90028.
Charles Cahill and Associates, Inc.
P. O. Box 3220, Hollywood, California 90038.
Carousel Films, Inc.
1501 Broadway, Suite 503, New York, N. Y. 10036.
Center for Mass Communication
Columbia University Press, 1125 Amsterdam Avenue, New York, N. Y. 10025.
Churchill Films
662 N. Robertson Boulevard, Los Angeles, California 90069.
The Cinema Verite Company
3116 - 16th Street, Room 27, San Francisco, California 94103.
Cook County Superintendent of Schools
The Chicago Civic Center, Room 407, Chicago, Illinois 60602.
Sid Davis Productions
2429 Ocean Park Boulevard, Santa Monica, California 90405.
Department of the Navy
Ninth Naval District, U. S. Naval Training Center, Great Lakes, Illinois 60088.
Family Films
5823 Santa Monica Boulevard, Hollywood, California 90038.
Film Distributors International
2223 S. Olive Street, Los Angeles, California 90007.
General Motors Corporation
465 W. Milwaukee, Detroit, Michigan 48202.
Alfred Higging Productions
9100 Sunset Boulevard, Los Angeles, California 90069.
Illinois Bell Telephone Company
225 W. Randolph Street, H. Q. 19-C, Chicago, Illinois 60606.
Illinois Department of Public Health
Bureau of Health Education, Film Library, 505 State Office Building, Springfield, Illinois 62706.
Illinois Medical Service
222 N. Dearborn Street, Chicago, Illinois 60601.
Indiana University
Division of University Extension, Audo-Visual Center, Bloomington, Indiana 47401.
International Association of Chiefs of Police
11 Firstfield Road, Gaithersburg, Maryland 20760.
McGraw-Hill Text-Films
330 W. 42nd Street, New York, N. Y. 10026.
Modern Talking Picture Service
160 East Grand Avenue, Chicago, Illinois 60611.
The Narcotic Educational Foundation of America
5055 Sunset Boulevard, Los Angeles, California 90027.
National Institute of Mental Health
Drug Abuse Film Collection, Distribution, National Audio-Visual Center, (GSA), Washington, D. C. 20409.
National Medical Audio-Visual Center
Annex, Chamblee, Georgia, 3005 Attn.: Distribution.
Naval District
Building 200, Navy Yard Annex, U. S. Navy, Washington, D. C. 20390.
Newenhouse/Novo
1825 Willow Road, Northfield, Illinois 60093.
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21 W. 46th Street, New York, N. Y. 10036.
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P. O. Box 8484, Universal City, California 91608.
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Engineering Building, Suite 1700, 205 West Wacker Drive, Chicago, Illinois 60606.
University of Illinois
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