Editorial: Who Benefits From the American Drug Culture?

Headlines in the mass media scream out day after day that a drug epidemic is engulfing our land. Heroin, they say, is no longer an affliction of the "amoral or ignorant" lower classes and black and brown ghetto dwellers alone; its use is spreading like wildfire among the children of the respectable, white, middle class. As the daily press fans the flames, and as frightened (and voting) middle class parents begin to demand action which will deal with "the problem," treatment "experts" and politicians are moving to the fore with the "solutions." For the past 30 years, when American addicts were primarily poor and from the black and brown communities, the same men who are now talking about "answers" were stone silent.

There is simply no comparison between the magnitude of the drug addiction problem in oppressed, black and brown communities and in a middle class setting. Even though a white addict may be isolated or shunned in his own society, the black and brown community itself is strangled by a "drug culture" which affects every man, woman and child who lives in the ghetto. A Muslim from Bedford-Stuyvesant, a follower of Malcolm X, describes the total destruction unleashed on his people and his community by the multi-million dollar heroin industry as follows: "The black community suffers the loss of its youth through physical and mental deterioration as a result of drug addiction. The black community loses financially because the only way for the junkie to exist is by stealing. The poor, ghetto addict who is now talking about "answers" were stone silent.

It could be argued that the relatively small and powerless populace of "hard" drug addicts was singled out as the perpetual whipping boy of a moralistic and puritanical America—whose more ambitious prohibition campaign was quashed by those who craved an alcoholic "high" when drinkers banded together to repeal the Volstead Act in the mid-30's. The narcotic addicts were labelled criminals and forced into criminal activity. Once the prohibitionists had created a criminal drug clientele, law enforcement agencies moved in to clear the streets. The affluent and middle class white communities—fearful that desperate black and brown addicts, might venture into their neighborhoods—threw support to those who adopted a "get tough" line.

And the resulting scare campaign—waged by both the politicians and the press in the 50's—led to the passage of extremely harsh measures which took no time to distinguish between the victim of the plague and the perpetrator of it. And now, the move afoot to reduce penalties for the mere possession of a drug (heroin or marijuana) and to increase the penalties for pushers, once again is in response of the needs of a frightened, middle class segment of our society. In effect, the "liberalized" laws only represent a liberalization for the drug user who can afford to purchase his drugs. The poor, ghetto addict (who must sell to support his habit) will continue to be prosecuted to the full extent of an even harsher law.

Harsh drug laws have been used not only against helpless individuals, but are increasingly being utilized as a means of political repression and control against two potentially powerful forces for social change—the third world community and the white, radical youth. After all, one must count on the honesty of the police when they report that an individual was carrying dope. Not only can politically "dangerous" individuals be picked off and sent away for years, but black militants point out a more pervasive function of drug control laws: "The existence of the junkie, and all that goes with his existence enables the white power structure to keep an army of police in our community, supposedly for our protection from the very same junkie that he created. While the police are busy protecting the black community, they manage also to control and contain us..."
Drug law History: Politics & Prohibition

America is a consumer society. Many of its consumers indulge in one “habit” or another—and American businesses, both “legitimate” and “illegitimate,” push products to meet the demand they help to create. Whether it be a housewife who turns to Librium to help her get through another tense or boring day in the suburbs, or a black teenager cropping a fix on the corner in an urban slum, the scene is similar—if you have the money, you can get “relief.” But the recent penetration of “hard” drugs into middle class society, as well as the fear of addiction-related crime against property in “good” neighborhoods has set up a public outcry which is reverberating in the mass media and the legislative halls. Since the early 60’s, politicians from urban areas have been under pressure from their constituents to find more success for great numbers of black and brown addicts. The very insistence of medical men and self-proclaimed “experts” that even if they don’t have answers now, that given enough time and resources they will find the panacea for addiction, is dangerous. Not only do such programs raise false expectations and absorb the energy of community people, but they provide a sate funnel for the limited government money going into treatment. If the white, middle class crusaders are really interested in combating addiction in the oppressed communities, they ought insist that considerable money be poured into the ghetto and let the community decide where to put it. Appropriate “treatment” to some blacks and Puerto Ricans might mean housing and jobs while to others it would mean setting up liberation schools to build black and brown consciousness. Community organizations—from local narcotic agencies to groups of Muslims, the Black Panther Party and the Young Lords—are beginning to serve notice on those who would exploit their people, both “the drug pushers and the professional program pushers.”

There is no quick legal or medical “fix” for drug addiction. Any such superimposed solution will at best only ease the pain of the drug casualties. Only when political struggle, waged by the people who are most oppressed in our society, succeeds in changing the conditions which are influencing entire generations to seek fulfillment, economic or spiritual, through drugs, will youth—black, brown and white—feel there is a meaningful alternative to drugs. Drugs are inundating and crippling oppressed communities with the tacit approval of the power structure, and the struggle against drugs can only be successful in the context of the struggle for total liberation. As Panther Michael Tabor says: “As long as our young black brothers and sisters are chasing the bag, as long as they are trying to cop a fix, the rule of our oppressors is secure and our hopes for freedom are dead. It is the youth who make the revolution and it is the youth who carry it out. Without our young, we will never be able to forge a revolutionary force.”
effective ways to sweep the addicts (i.e., the non-white burglars, the muggers, the thieves) off the streets. Nelson Rockefeller based his 1966 campaign for the Governorship of New York on a civil commitment program, which was called “treatment” to assuage the reformer conscience, but in reality merely made it easier to pick up more addicts and put them away for longer periods of time without burdening the courts. In 1965, John Lindsay pointed to addiction as a serious problem, and partly on the basis of his promise to do something about it, he was elected Mayor of New York. Richard Nixon picked up on the popular theme emanating from New York and, after campaigning successfully on a “law and order” platform, last fall submitted a “get tough on pushers” drug-control bill to Congress.

Such political appeals to the public’s fear of addicts and addiction are an attempt to capitalize on what the newspapers call a growing “epidemic.” There are an estimated 300,000 heroin addicts in this country. US heroin addiction rates have climbed faster than in any other Western country. In the last 20 years, the number of known addicts has increased 300 percent. Forbes Magazine states the magnitude of the problem in business terms: “It’s an industry that runs to nearly $3 billion a year in the US alone... It’s a real growth industry, expanding in the US at 10 percent or more yearly.” The US addiction rate is 30 times that of Italy, Belgium, Russia, Poland and Brazil; 10 times that of Britain and France; and twice that of Canada. (In the early 60’s, the census of addicts in any given European country rarely exceeded 500 individuals. It is possibly of some social significance that the severest drug problem in European history was recorded in pre-World War II Germany, which saw a phenomenal growth in addiction to hard drugs. By the time the war commenced there were at least 10,000 known German addicts.)

The white middle class’s increasing concern over addiction comes not merely from the growth in addiction, but from the fear of being victimized by the same drug evils that have plagued the ghetto communities for years. Not only might ghetto addicts boldly venture into the white community to steal goods to support their habit, but middle class teenagers are getting hooked on readily available heroin. The ensuing publicity and concern has all but obliterated the fact that black and brown communities are still the primary victims of drug addiction. Most drug-related crime [see Box, Page 10], involving an estimated $15 billion in property loss each year, is still committed in the ghetto. Notwithstanding, the fears of the white middle class have increased, and the poor communities have been placed in double jeopardy by the “law and order” campaigns of politicians which reinforce an already repressive police force.

Now the fear of violence in the white middle class community has given way to another fear: Addiction itself has penetrated some of its most coveted institutions—suburban schools and business and industry, (even so, 75 percent of addicts are from minority groups). Alarmed parents in such places as Smithtown, Long Island, Clifton, New Jersey, and Grosse Point, Michigan, are insisting that school officials give their children saliva, blood or urine tests to determine what drugs they are using. Even big business is worried. Last fall 60 top business executives who make up the Commerce and Industry Association devoted their annual meeting learning how to recognize addiction among their junior execs. And this spring, top officials of the UAW admitted concern about reports of widespread use of narcotics in the plants.

Confronted by an alarmed, middle class public, most politicians are adopting a modified line about addiction: The Establishment is shifting the onus of criminality from the drug user to the drug pusher, while searching frantically for a medical “fix” with which to treat the victim. Even President Nixon, who as recently as last summer was calling for increased punishment of drug users, has realized such laws can be applied to the parents and daughters of his own constituents (and in any event, have proven unsuccessful). After due consideration, he said in a message to Congress last fall: “It has been a common oversimplification to consider narcotics addiction or drug abuse to be a law enforcement problem only.” But Nixon is a mere upstart compared to New York’s Governor Rockefeller when it comes to blowing with the wind. The same Rocky who ran unabashedly on a “sweep the addicts off the streets of New York” platform three years ago, only a few weeks ago told a conference on drug abuse: “Curing addiction is one of the toughest jobs in our society. It would be a tragedy if there were those who tried to make political gain from the suffering and degradation of narcotics addiction.”

New York City’s Mayor Lindsay has also gained considerable political mileage from the drug crisis. A year ago, just before the primaries, Lindsay announced the formation of a Federal-City Narcotics Enforcement Task Force in a joint news conference with US Attorney General Mitchell. The task force still doesn’t exist. Then in October, 1969, just days before election day, Lindsay joined Senators Javits and Goodell in calling for a “moonshot” war on drugs and requested $1.5 billion in Federal funds for a five-year program. Even though the money didn’t arrive from Washington, Lindsay continued to seek drug headlines. Within a few weeks of his re-election, Lindsay announced the appointment of Robert Morgenthau to the newly created post of Third Deputy Mayor Morgenthau, a crime-busting former US District Attorney, was assigned to clean up the drug problem in February. Lindsay established a City Narcotics Control Commission and made Morgenthau the chief. In March, the new Third Deputy Mayor announced his candidacy for the Democratic nomination for Governor. And in April, just two and half months after the fanfare of another call for a total war on drugs,
Morgenthau retired to run for the Democratic nomination for Governor, using the drug problem as a major campaign issue. The office of Third Deputy Mayor was phased out.

Many politicians are beginning to pay lip service to the plight of the addict-victim and a smaller number are fighting for increased appropriations for the treatment of addiction. But they are up against all the problems left by a 50-year history of laws which force addicts to become criminals. All forms of addiction, though rooted in the social experience of individuals, are shaped in part by society’s attitude toward addiction and by the controls it imposes. In America (and through America’s influence, in much of Asia) the use of “hard” drugs was prohibited in the early part of the 20th century. [See Box, Page 6.] In so doing, the society forced the addict to become a criminal to survive. Moreover, if he were part of an oppressed minority group, he might actually be attracted to this one facet of the economy which was “open” and offered opportunity. And if he were a successful hustler, he might gain considerable respect among his peers, in most European countries, by contrast, where addiction to “hard” drugs was viewed as just another medical problem with a prescribed treatment such a drug subculture never gained momentum. The “British system,” for example, merely authorized physicians to write prescriptions for heroin. Recently an unprecedented jump in addiction prompted the British to switch from self-administered drugs to a more formal system of clinic dispensaries.

Whether the recent increase in addiction is attributable to Britain’s “liberal” policy regarding addiction, or whether it has other social bases, is presently being debated.

The prohibitionist attitude toward drugs which led to this country’s law enforcement approach to drug addiction, has its roots in the last half of the 19th century. Drug addiction was growing at home. “Soldiers’ sickness,” or addiction to morphine, afflicted more than 45,000 Civil War veterans as a result of the liberal administration of the pain killer on the battlefield. By the end of the war, many others had taken to opium smoking which had been introduced by the Chinese who emigrated to the US during the 1850’s and 1860’s. Though many continued to think of opium smoking as strictly an oriental sport, more than half the imported opium reached the general market. At the same time, a flourishing patent medicine industry found that a touch of opium or morphine could ease almost any pain—and, coincidentally, sell a lot of bottles of medicine. As America turned the corner of the 20th century authorities estimated there were at least 100,000 addicts to morphine, opium and heroin.

The discovery of the drug addiction problem around the turn of the century coincided historically with the campaign to rid the nation of another scourge—alcohol. Both the general prohibitionist sentiment of the era and a specific collection of men in the Treasury Department who were charged with the enforcement of the Volstead Act were influential in labeling the addict a criminal. The American delegation attending the first International Opium Convention at the Hague in 1912 pushed very strongly for international drug controls. When no such controls could be agreed on, the delegation returned home determined to clean up its own backyard. The US made her first stab at controlling the flow of narcotics in 1914 by pass-

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**MEDICAL POWERS PUSH LIBERAL DRUG BILL**

Three powerful lobbies — the AMA, the APA (American Psychiatric Association, and the PMA (Pharmaceutical Manufacturers Association) — are throwing their considerable combined weight behind a liberal drug control measure which is now being considered in the US Senate. Even though they have the choice of another, more conservative bill, these groups have jumped the fence; Dodd bill means they have become addict advocates and friends of oppressed people? Hardly. The motivation for switching lies more in the realm of jealously guarded research grants, the doctor’s right to privacy and drug industry profits.

The first of the two bills, the Administration-backed Dodd bill, would give all powers (enforcement, treatment and research, and education) to the Department of Justice. The second, the Hughes/Kennedy bill, however, reserves the responsibility of treatment and research and education on drugs for the Department of Health, Education and Welfare. Both bills talk about the need to soften the penalties for possession and use of drugs (both marijuana and heroin) while getting tougher with the pushers. Both bills talk of the need for education about the dangers of drugs, though the Hughes bill is a little weightier in this respect. Though the Dodd bill seemed virtually assured of passage earlier this year, it now appears to be in trouble. There is no indication when either bill (Dodd was introduced last fall and Kennedy late this spring) will be reported out to the floor for a final vote.

The AMA-APA-PMA axis’ objections to the Dodd bill revolve around three areas of power to be vested in the Office of Attorney General Mitchell: (1) the “no knock” provision which says Federal agents may break into a house and make arrests without a warrant if they have probable cause to believe the person they are about to arrest has committed a felony and that he will destroy the evidence if warned by knocking; (2) the power to designate a drug a “dangerous substance” subject to control, and to set production quotas for drugs according to “medical, scientific and industrial needs of the US”; and (3) the authority to enter into contracts with public agencies, institutions of higher education and private organizations or individuals for research and...
The Hughes bill meets most of the objections of the drug and medicine lobbyists. It would set up a Drug Abuse, Prevention, Treatment, and Rehabilitation Administration in HEW which in turn would establish a nationwide system of regional and community health centers for addicts. Grants would be provided to state, local and private agencies to educate the public about drugs. A booster for the Hughes/Kennedy package, Daniel X. Freedman, of APA and the chairman of the University of Chicago Department of Psychiatry, put it this way: "The bill envisages realistic grants to private and public facilities which professionally qualify and intend to deliver drug control regulations which were issued in 1921 were based on the Supreme Court decisions and bore the definite stamp of the prohibition mongers. Their influence is most starkly reflected in the fact that 44 narcotic-dispensing government clinics which had been opened in 1919 under the reign of Internal Revenue Service, were summarily ordered closed in 1920 by the Prohibition Commissioner.

Legally, medical alternatives to the "law and order" interpretation of the Harrison Act, were still not ruled out. Had anyone chosen to challenge the Court's early decisions and the ensuing Federal regulations, a Supreme Court decision handed down in 1925 might have served as an opening wedge. The case involved Dr. Charles Linder from Seattle who, unlike the doctors in the earlier cases who were involved in prescribing rather large quantities of drugs, supplied only four pills, to be used for withdrawal, to an informer posing as an addict. The Court cleared Dr. Linder of charges, described addiction as a disease, and said that a physician acting in good faith could give drugs for withdrawal. But instead of spurring reform, the Linder incident—which cost the doctor over $30,000 and a two year loss of license—probably did more to insure that doctors would stay clear of addicts. After all, they reasoned, bad publicity—whether you win or lose—could cost a man his career.

Organized medicine—through the voice of the American Medical Association (AMA)—was less than valiant when it came to fighting for the health and welfare of addicts. But it is probably safe to say that their attitudes were a fair reflection of the attitude of the medical profession in general. They not only willingly acquiesced to the Treasury Depart-

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American businessmen were profiteering from illicit drug traffic long before the Mafia got in on the action. By the mid-19th century, the participating US merchants—whose contributions of tobacco, pipes and fast clipper ships had enhanced the sales—were eased out of the trade by their more established British counterparts. Britain, operating with the advantage of a colonial master, had begun cultivating poppies (the source of opium) in her Indian colony in the middle of the 18th century. From her Indian base, the East India Trade Company raked in tremendous profits through the sale of the opium it smuggled into China.

Eventually, opium became the excuse for Britain to pry open the doors of China's markets to receive other British products as well. Even though a prohibition on opiates in China had existed since 1729, the drug trade flourished. Britain was anxious to market other products in China and eagerly seized upon an incident involving the destruction of illicit opium as an excuse for declaring the first Opium War in 1842. The treaty settling the war gave Hong Kong to the British and established British trading privileges in five formerly prohibited Chinese ports, but didn't even mention opium. In 1856, Britain once again declared war on China and was joined this time by France, who claimed to want to avenge the death of a French missionary. The treaty which settled the conflict in 1858 granted the right of entry into China of both opium and missionaries. The association of the "two mind-benders" was not lost on the Chinese. In 1869, a Chinese prince—realizing that opium is at least as powerful an "opiate of the people" as religion—told a British official, "Take away your opium and your missionaries and you will be welcome."

A century later, Malcolm X, who had been a heroin addict, recalled the plight of the Chinese: "... The collective white man had acted like a devil in virtually every contact he had with the world's collective non-white man. The blood forebearers of this same white man raped China at a time when China was trusting and helpless. Those original white "Christian traders" sent into China mis-

ment regulations, but wholeheartedly endorsed the closing of the government drug clinics. Picking up on the rhetoric of the prohibitionists, a spokesman for the AMA said in 1921: "The shallow pretense that drug addiction is a disease which the specialist must be allowed to treat, which pretended treatment consists in supplying its victims with the drug which has caused their physical and moral debauchery, has been asserted and urged in volumes of literature by self-styled specialists. The vice that causes degeneration of the moral sense, and spreads through social contact, readily infects the entire community, saps its moral fiber, and contaminates the individual members one after another like the rotten apples in a barrel of sound ones." Until the late 50's, the AMA consistently and vehemently opposed all "ambulatory methods of treatment of drug addiction, whether practiced by the private physician or by the so-called 'narcotics clinic' or dispensary."

Through organized medicine opted out on its responsibility to treat the addict, the federal Public Health Service lent medical respectability to the federal addiction program by setting up federal "hospitals" to get the addicts off the streets in the 30's. Procedures for criminal and civil involuntary commitments were adopted. The treatment centers which are in Fort Worth, Texas, and Lexington, Kentucky were traditionally long on detention and short on treatment. Even their own statistics reveal that fewer than three percent of their "graduates" have been "cured."

From the 20's to the 50's, lawyers showed as little interest in protecting the addict's legal rights as did the doctor in considering his health rights—and for many of the same financial reasons. Narcotics laws as defined by the Treasury Department and enforced by the Bureau of Narcotics (established within the department in 1930) until very recently made little distinction between the perpetrator of the crime and the victim of it. And in practical terms, the victim received the harsher treatment of the two—either at the hands of the police and in the courts. And given the choice of an addict or a peddler to defend, the lawyer is more likely to choose the man who can pay. Records show that higher courts spend a disproportionate amount of time on the constitutional rights of traffickers (illegal search and seizure cases), rather than on the same constitutional rights of addicts which may have been abused.

Before 1930 and the creation of the Bureau of Narcotics in the Treasury Department, addiction was considered a Federal concern almost exclusively. The newly formed Bureau quickly sought the cooperation of the States in an effort to fill possible gaps in the law. Most States responded by adopting a suggested Uniform Narcotics Law which was similar to the Harrison Act although many of the penalties, which varied from state to state, were often even harsher. Many of the state laws added marijuana in the list of dangerous narcotics. The Federal law which authorized the establishment of Lexington and Fort Worth Hospitals in 1929 also defined marijuana as a "habit-forming narcotic drug." With the way paved, the federal government passed a Marijuana Tax Act (similar to Harrison) in 1937.

The laws remained pretty much intact under the 1951 Kefauver hearings on organized crime triggered a public outcry for increased punishment for those involved in
controls most information on narcotics which ficking and, in so doing, gained some favor interest in the profitable opiate export business, with Chinese-invented gunpower. The treaty Britain's medical approach to addiction. The widely circulate a report which debunked problem—has been highly critical of non-re establish need. The Bureau—though it failed to produce data to show effectiveness or is disseminated at the Federal level, it is able italized on the "signs of the times." Because of Justice in 1968)—has enthusiastically cap the Treasury Department to the Department of Justice (1968)—has enthusiastically capitализed on the "signs of the times." Because it has a large public relations budget, and it"s more rhetoric than reality. In 1962, the two states with the greatest narcotics problem in the US, New York and California, followed in the footsteps of the federal government which had set up civil commitment procedures for Lexington and Fort Worth in the 30's, and instituted state civil commitment programs [see description of New York civil commitment, Page 16]. Because these Federal and State programs are billed as "rehabilitation," not as "punishment," the addicts committed to such institutions are often denied even basic constitutional rights—e.g., it is only recently that the courts required a jury trial before commitment in New York. Since 1960 there has been a general reappraisal of the harsh punishment of drug users although the "reappraisal" has been more rhetoric than reality. In 1962, the two states with the greatest narcotics problem in the US, New York and California, followed in the footsteps of the federal government which had set up civil commitment procedures for Lexington and Fort Worth in the 30's, and instituted state civil commitment programs [see description of New York civil commitment, Page 16]. Because these Federal and State programs are billed as "rehabilitation," not as "punishment," the addicts committed to such institutions are often denied even basic constitutional rights—e.g., it is only recently that the courts required a jury trial before commitment in New York. A few months ago, New York City followed in the footsteps of the Federal and State moves to restrict the addict by instituting what was in effect a compulsory treatment program for the addict's "own good."
President Nixon made a splash in the press this March when he announced he would get to the "source" of the heroin problem by signing agreements with the countries which cultivate poppies and manufacture most of the heroin—Turkey and France, respectively. The new treaties, which provide subsidies for local police, are contributing considerably to US-supported police forces around the world.

The primary targets of the Nixon war against drugs would be the opium farmers of Turkey and Mexico and the heroin distilleries in France, particularly in Marseilles. Authorities claim that of the three tons of heroin which are smuggled into the US each year, that 80 percent of the original opium poppies are cultivated in Turkey and 15 percent in Mexico. And the Marseilles heroin distilleries, they say, are to the drug industry what Detroit is to the auto industry.

The spoils? Turkey will get a $3 million loan to encourage her farmers to switch from opium to other crops. Along with the money, Turkish officials will get narcotics-fighting "equipment" with which to train a new narcotics police force—ranging from spotting planes to guns and ammunition. Increased cooperation with France also means "mutual police training programs." Not to neglect other countries, the US will beef up the number of narcotics officers assigned to embassies and foreign missions. In addition, the US Bureau of Narcotics, which now has offices in 12 foreign countries, will establish offices in another five.

In announcing the new bilateral pacts with France and Turkey, Nixon stressed the point that narcotics traffic enforcement is too important and complex to be left to the police, and promised to throw the weight of the entire diplomatic corps into the fight against drugs. So far, most diplomats have kept hands off the local narcotics trade, which often involves prominent local businessmen and public officials. For instance, the US diplomatic corps would be the last people to interfere with the thriving cocaine industry of Peru. Friendly Peruvian businessmen profit from the manufacture and smuggling of cocaine to the US and besides, the Peruvian power structure needs the coco plants to pacify the Andean Indians, who fight hunger and despair by chewing coco leaves.

Another miscalculation on Nixon's part was his "Operation Intercept" at the Mexican border last summer. The Mexican government was infuriated when this massive border blockade almost destroyed the tourist trade. Nixon exonerated himself this spring by giving a parcel of money to Mexican police officials to conduct "Operation Cooperation." The control emphasis has shifted from the border to an all out war on the poppy (and pot) crops. The arsenal supplied by the US will include airplanes equipped with special drug-sensing devices and crop defoliants.

Actually, the illicit flow of hard drugs into the US pales when compared to the uncontrolled flow of "legitimate," though equally debilitating, drugs from the US into the foreign marketplace. This spring, a UN commission on narcotics control fought a losing battle to institute "soft" drug control measures patterned after those controlling "hard" drugs. Countries with developed pharmaceutical industries, led by the US, West Germany, Canada and Japan, rallied to defeat the measure which would have severely cut into the profits from about 100 different drugs (hallucinogens, amphetamines and tranquilizers).

The City Department of Social Services issued an administrative order which denies public assistance to an addict unless he is in treatment or a definite treatment commitment is agreed to. The Commissioner of Social Services Jack Goldberg, claims the City is looking for a better return on its $5.7 million per year which goes to a minimum of 6,000 addicts. Goldberg assures critics "the junkie will be exposed to a whole series of treatment programs." But there are already waiting lines for all the treatments (effective or ineffective) that exist in the city. What is more likely to happen is that these addicts will find themselves in "treatment" in the prison-like State narcotic rehabilitation centers which have been operating at 25 percent below capacity.

At the Federal level, officials are trying to capitalize on the political potential of the drug issue, and respond accordingly. Last year, Nixon's newly appointed head of the Bureau of Narcotics and Dangerous Drugs, Robert Ingersoll, sensing the Congress was shifting toward waging war on the pushers while relaxing the penalties on drug users (since many of their sons and daughters were being picked up on dope charges), told a Congressional committee: "Our major concern is with [drug traffic's] criminal aspects. . . . A greater effort will be expended now and in the future to apprehend and prosecute major drug traffickers and also to prevent violation of the drug and narcotic laws, especially among the young, the naive, and ordinarily law-abiding public." Congress granted his request for a program of training and staffing foreign narcotics posts, an incentive plan to persuade foreign growers to stop producing opium [see Box, this page], substantial increases in border guards and agents for both Federal and local narcotics bureaus and increased research and education into the Drug problem. The Bureau's estimated 1971 budget, $34.5 million, almost double that of 1969, reflected the Administration's stepped up spending for drug law enforcement.

In his first major statement on drug addiction in the summer of 1969, President Nixon took a hard line. Among other provisions, Nixon recommended that marijuana use be treated as a felony. This put lead in his trial balloon, and Nixon liberalized the plan under heavy criticism from such men as Sen.
Gaylord Nelson who said "it is heavy on policing and weak on rehabilitation." Subsequently, the White House bill was incorporated into the Dodd bill. [See Box, Page 4.]

Meanwhile, back in New York State many legislators in Albany were aghast this spring, when the appropriations bank was broken and the legislative session was drawing to a close, and Governor Rockefeller announced a $285 million "declaration of total war" against drug abuse by those under 16. It's the year of concern for the teenage addict—and Rocky, up for reelection, knows a good issue when he sees one. Many Democratic legislators from New York City made a counter "declaration" that Rocky's "war" was a hoax. Nevertheless, Rocky's call for the legislature to trim $64 million from other programs so it could be made available on a 50-50 matching basis to localities—localities which would find it next to impossible to raise cash for teenage drug programs—was heeded. It would have been political suicide for critics to do otherwise. The remaining $200 million of the Rockefeller "war," for construction or leasing of facilities for youth treatment centers, was to be provided by State housing bonds to provide loans to local governments. But the lion's share of Rocky's war made headlines then disappeared.

The much publicized shift in public policy toward addicts—from one of punishment to one of treatment—will probably not mean much to most addicts. Even though the penalty for "possession" has been eased, it will mainly benefit those who can afford to buy their drugs and do not have to push to make money to support their habits, as is the case with most lower class addicts. It is true that there are now many in the medical profession who are willing to treat addicts. Even the AMA, which for decades supported a "law and order" line, came full circle last winter when it declared: "drug-dependent persons should be treated as patients rather than criminals." But little money is available for "treatment"; most of the effort still goes to repression. Moreover, in the past, "treatment" has most commonly been nothing more than a euphemism for imprisonment. Finally, really meaningful treatment means changing the conditions which lead to addiction. Even if a medical "cure" for addiction were found tomorrow, poor people would still lack meaningful employment, decent housing, good schools, etc.; the conditions that generate addiction would remain untouched.—Maxine Kenny

**ASA:**

*"There are Enough Junkies for all of us"*

Drug treatment programs are the most popular "hustle" to hit New York since poverty programs passed from vogue a few years ago. And like its predecessor, very few of its resources are reaching the "target" population. A recent survey shows that the more than 50 residential centers for addicts (and over 100 outpatient facilities) are part of a multi-million dollar addiction treatment industry—ranging from church programs, voluntary hospitals, and private corporations to City and State agencies. Several of the sponsors have succeeded in building "mini" empires through sheer press release fanfare, hublabalo and hutzpah. But despite the fact that money is flowing into their programs, the professional entrepreneurs who are making names for themselves as "experts" have failed to "cure" more than a handful of the thousands of addicts who have passed through their doors.

Treatment available to the New York addict ranges from imprisonment, to sipping a paper cup full of methadone in orange juice, to the group therapy provided in therapeutic communities run by ex-addicts and/or psychotherapists. Officials who run the public programs for the State and the City claim its only a matter of time before their programs start showing good results. But when pressed for figures, the picture which emerges is a gloomy one. An official of the New York State Narcotics Commission [see Box, Page 16] which provides some degree of "care" for about 11,000 addicts to the tune of $50 million a year, says he feels there have been "perhaps a couple hundred cures." And the City Addiction Services Agency, with a $29 million plus yearly budget, claims 79 "cures" out of the 2,500 addicts it has treated since the agency was created in 1967. Both the State and City agencies funnel money to other public and private treatment facilities as well as run their own services. Even though New York City leads the nation in variety of treatment and the numbers of facilities, it is estimated that fewer than three percent of her 200,000 addicts ever receive any treatment, good or bad.

Lack of treatment for addicts is nothing new. Until 1950, when the mass media proclaimed a heroin "epidemic" in New York City—some claim the 50's "epidemic" was worse than the present day one—few New Yorkers thought of addiction as a problem. Any addicts or pushers who were arrested were hustled off to Federal drug facilities in Fort Worth, Texas and Lexington, Kentucky. Many white, middle class addicts journeyed there to take the "cure" voluntarily. Then came the "epidemic," and Governor Thomas Dewey responded by pressing the City's Department of Hospitals to open a 141-bed hospital on North Brothers Island. This facility, Riverside Hospital, was a co-educational facility intended to rehabilitate (mostly minor-
FROM DRUGS people maintain that the police commit more drug related crime—for greater profit—than addicts. The addicts are accused of crimes in the white communities that they seldom commit, they say, though the cops are seldom accused of profiting from drug traffic in the ghettos.

Occasionally a policeman is dumped from the force for accepting a payoff from big-time narcotic dealers, but a recent New York Times expose reveals that corruption goes beyond a few "bad apples." The narcotics detail is a coveted position in the New York Police Department because of the volume of cash which flows to most officers, even the desk sergeant.

An over-zealous press—which quotes statistics provided primarily by politicians and police—continues to present a distorted picture of the relationship of drug addicts to society group adolescents. The hospital came under heavy public attack in the late 50's for being a den of vice, and the State Commissioner of Health began to look for a way out. He turned to the Columbia School of Public Health for an evaluation of the situation, and Dr. Ray E. Trussell produced a study to show the facility had been almost 100 percent ineffective as a treatment facility. Though the politicians wanted to close the hospital immediately, they were unable to do so because of the resistance of the staff—that is, until Dr. Trussell was named City Commissioner of Hospitals in 1961 and, as one of his first acts in office, ordered the hospitals closed.

From the closing of Riverside Hospital until the therapeutic communities took root in 1965, very few treatment doors were open to the addict. Ex-Hospital Commissioner Ray Trussell proudly recalls how he personally pressured his City hospital administrators into donating a grand total of only 25 beds (out of 16,000) to the service of pregnant addicts. But in the early sixties, the Health Research Council (the City agency which funnels public money into research), called addiction research a top priority, and set up a committee to study the problem. Its chairman, Dr. Vincent Dole of Rockefeller University, applied in 1963 for a $100,000 grant from the Council to do research on addiction. When the grant ran out, Dr. Trussell encouraged Dr. Dole and Dr. Marie Nyswander (his research partner and wife) to expand their research by a cost much lower than institutional care. The logical target population for such a venture was the "crime-prone addict." Mayor Lindsay called on his friends at the Vera Institute of Justice (a well-heeled civil-liberties-oriented institution in New York City) to work up a plan. The blueprint was unveiled in the spring of 1969, shortly before the mayoral primaries. By fall, the money had arrived from Washington, and Lindsay held another timely press conference at the dedication of a newly purchased and renovated facility in Bedford-Stuyvesant—this time on October 8, just a month before he would be up for re-election. (Insiders say that not only was the hastily prepared application pushed through the Federal bureaucracy—bypassing all review processes—but that when the doors to the center opened with the Mayor's press conference, that none of the agencies work-
ing with addicts in Brooklyn had been in-
formed of the plan.) The Mayor's political op-
opponent, conservative candidate Mario Pro-
accino called it as he and many others saw it: 
"The sheer gall of this man Lindsay is be-
yond belief. He fought the methadone main-
tenance program as long he could, as hard as he could." [As the BULLETIN goes to
press, Lindsay has announced a 1970-71
budget which provides $7.7 million dollars
to not only expand the Vera program, but to
provide methadone through the City's 20
District Health Centers.]

The Vera methadone program, which is
primarily an out-patient service, has been
driven with problems since it opened in Bed-
ford-Stuyvesant last fall. The Vera program,
unlike the Beth Israel prototype, talks about
maintaining the addict on methadone only
until he has gotten himself together through
therapy and a variety of social services, and
then gradually reducing the methadone until
he is drug-free. The program has been caught
in a cross-fire of attacks—from pro-metha-
done-maintenance men who allege the Vera
program people are basically aligned with
the therapeutic community concept and that
their deliberately sloppy operation will make
a bad name for methadone; and from anti-
methadone black and brown community
members who say the addicts are drugged
senseless on methadone and that the program
serves as an instrument of repression.

Critics claim that poor medical practices,
irregular and inconsistent dosages of methadone (as a matter of practice to see if
addicts can be withdrawn, and as a matter of poor procedures, i.e., staff wanting to leave
early, etc.) have led to the deaths by heroin
overdose of at least five patients out a
patient load of less than 200. The overdoses
happened, say people who work in metha-
done-maintenance programs, because the add-
dicts' level of methadone dropped so low
that they felt a craving for heroin, shot up,
and died as a result.

According to the director of the program,
Dr. Beny Primm, a black anesthesiologist from
New Rochelle, everything is A-OK. The Vera
program—officially known as the Addiction
Research and Treatment Corporation—is set
up as a private, non-profit corporation with
non-existent—a crucial link to hospital-based
emergency, inpatient and psychiatric care,
which originally had been agreed upon with
nearby Brooklyn-Cumberland Medical Cen-
ter, was broken off almost as soon as the pro-
gam got underway.

The father of methadone maintenance, Dr.
Vincent Dole, used harsh words to describe the Vera program. In a letter to Herbert Sturz,
Director of the Vera Institute, in May, 1969,
Dr. Dole said of the proposal: "It is a med-
ically naive, unworkable mess—in my opin-
ion, that is. . . . The administrative and
clinical personnel that would be needed to
operate such a program do not exist, at any
salary, apart from the personnel that we
have trained. . . . You have a 10 ton airplane
with a one horsepower motor." He saw the
whole thing as a plot. "Mayor Lindsay now
can make the next step [apply for the funds
to run the program], which is to ruin the ex-
isting program by setting up a duplicating
organization with higher salaries to take
away key personnel. . . ." The mayor would
do better, Dr. Dole maintained, if he put $5
million (less than half the budget of ASA)
into methadone maintenance, preferably ad-
ministered by the Beth Israel Medical Center.

On the therapeutic community side of the
treatment picture, Odyssey House—privately
owned and operated—has shown the great-
est growth outside the City's own Phoenix
House program. Odyssey House has used
State money, saturation advertising, solicit-
ing and such gimmicks as "rummage sales" at
Abercrombie & Fitch to contribute to its
phenomenal expansion from one house with
65 addicts in 1967 to six houses and 253
addicts and a one and one half million dollar budget at the present. Odyssey is a family
affair: directed by Dr. Judianne Denson-
Gerber (psychiatrist and lawyer); her moth-
er is on the board of directors; her lawyer-
father represents Odyssey in legal hassles;
and her husband heads an advisory council
which includes Senators Javits and Goodell,
four assemblymen, seven judges and such
other notables as Bill Graham of the Fillmore
East rock concert hall and Roy Campanella.
Her teenage programs get a constant boost
from her husband, Dr. Michael Baden, who,
as the Assistant Chief Medical Examiner for
New York City, does more to remind New
Yorkers of the daily deaths of the addict,
especially the teenage addict, than CBS
News does to record the number of "enemy"
dead in Vietnam, Laos and Cambodia. Doc-
tor Judy, as she is known in the House, bases
her periodic and dramatic pushes for more money, more facilities, and more publicity on the figures her husband adds up and releases with dramatic narrative to the daily press.

In recent months, many community people have banded together to fight what they see as objectionable methods on the part of Dr. Denson-Gerber. They object to the way she displays “her children” (the teenage patients) in order to gain support for her programs. One of her more recent exploits involved holding a slight 12-year-old Puerto Rican boy on her lap at a State Legislative hearing on Juvenile Delinquency, while he told stories of mainlining. Several Senators were reduced to tears, and later the boy went up and down the aisles of the hearing chamber selling Odyssey House buttons for five dollars each. Dr. Denson-Gerber took the child along to Chicago a few days later for an appearance at a meeting of forensic medicine specialists. Then, much to her embarrassment, the little boy left Odyssey and returned home. He's older brother told the press his kid-brother was never an addict, that he had been coached to say “those things.”

At least three times in recent months community people have rallied—for different reasons—to keep Odyssey House from moving into their neighborhoods. The first show stopper was in the poverty-torn Hunts Point section of the Bronx. In the fall, the Community Progress Center (the Hunts Point poverty agency) invited a coalition of about 12 community groups—representing existing narcotics programs and community-based organizations with narcotic units—to act as “advisors” to design a comprehensive proposal for addiction treatment which the agency would submit to the Federal government for funding. After drawing up the plan, the “advisors” decided that not only should they advise, but that the community should receive the funds and determine how they should be spent. Meanwhile (in February), word reached the coalition that Dr. Denson-Gerber (who had been running an Odyssey House in the neighborhood for three years) was about to seal a deal with the Community Progress Center by which she would be the recipient of any forthcoming poverty funds. The coalition, through a confrontation, forced both the poverty agency and Dr. Denson-Gerber to back down. Of course, the community people said, if Dr. Denson-Gerber was interested in working in a community-planned and controlled drug program, they might consider funding Odyssey along with several other projects. Dr. Denson-Gerber responded: “The community is not going to tell me how to run my program,” and picked up her papers and went elsewhere.

The following month, Dr. Denson-Gerber was accused of “blockbusting” in the posh

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### THE CHANGING FACE OF THE ADDICT

The history of opiate addiction in this country goes back to Civil War days when many soldiers were treated with morphine to kill pain and opiate tinctures for dysentery. The hypodermic needle was also first used at that time. Between the 1860's and the passage of laws restricting opiate sale and usage in the early 1900's many more people became addicted via their physicians and patent medicine quacks. Almost all of the magic potions and liquids sold over the counter had significant amounts of opiates in them. Thus, at the turn of the century, women addicts outnumbered men addicts three to two, and most addicts were middle-class and thus almost entirely white. In addition, there were significant numbers of rural southern whites who were addicted via the “magic” elixir route. Significantly, blacks were almost never addicted at that time.

With the passage of the Harrison Act in 1914, the stage was set for heroin (which was first synthesized in 1898) distribution to be transferred into the hands of the underworld. The social and political impact of heroin prohibition had been profound. What the prohibition did was to single out one sub-group of drug abusers and label them criminals, while simultaneously denying them access to their drug supply. This forced the addicts into a life of economic crime which was necessary in order to pay for their habits.

During the 20's and 30's, addicts became increasingly urban males and for the first time, significant numbers of black addicts appeared. By 1945 males out-numbered females six to one, although whites still outnumbered blacks three to one. A recent survey (1969) of several addict treatment centers in New York indicates that the ratios have now become: blacks 40 percent, Puerto Ricans 35 percent, whites 25 percent. The most significant recent changes are the dramatic increases in the number of Puerto Rican and white middle-class youth. Despite the recent appearance of white middle-class addicts, “drug culture”-oriented middle-class white youths are, to a large extent, still sticking with consciousness expanding drugs (pot, LSD, mescaline, etc.) and staying away from the addicting drugs (heroin, barbiturates, amphetamines, alcohol).

Heroin addiction has found one middle-class constituency—health workers, especially doctors. A study by Dr. Charles Winick describes physician addicts as private practitioners who are extremely competitive and competent, who worked long hours, who feel alienated from the medical profession and in addition have significant marital problems. Winick further noted that prior to their addiction to opiates, 17 percent of these physicians were heavy drinkers. He hypothesizes that a significant number of these physician-addicts were experiencing severe role strain, which he defines as difficulty in making the transition from a small town, lower class background to the lifestyle of a middle-class physician.—Dr. Donald Goldmacher, Member, New York Medical Committee for Human Rights
East 80's. She said she was only trying to move "her children" into some empty apartments which had been offered to her by a generous landlord. The angry owners of neighboring brownstones who showed up to try and block the group from moving in said they had no objection to Odyssey itself, that "it's doing a wonderful job," but that the landlord was using the addicts to try and scare the other tenants into abandoning their apartments. Furthermore, they said, the landlord was trying to get the homeowners next to him to sell out so he could build a 37-story luxury highrise. The landlord admitted that he planned to build the highrise, but maintained that only money had all the land he needed. Odyssey moved in despite the protest, and Dr. Densen-Gerber commented, "Maidman [the landlord] is an angel... I don't know where we'd be without him."

The third incident involved the residents of Bushwick in Brooklyn. Dr. Densen-Gerber had received an enormous amount of publicity, including two lengthy and laudatory editorials in the New York Times, concerning the fact that Odyssey was the only facility which catered to the teenager (in fact, all but one of the houses are adult residences) and if she didn't find shelter for them they would be forced to sleep in the street. Mayor Lindsay magnanimously and with some fanfare offered a vacant hospital building in Bushwick. When Dr. Densen-Gerber arrived in Bushwick to claim the Evangelical Deaconess Hospital, she found it occupied by community residents who insisted the Mayor had promised it to them as a day-care facility. Frustrated with City officials, she took her story (and 70 teenage Odyssey residents) to Albany to meet with State legislators. The delegation staged a memorial for the teenage addicts who had died so far in 1970 and then Dr. Densen-Gerber and "her children" joined hands to sing "Somewhere (there's a place for me)" from the score of the West Side Story. At this point a group of angry black and Puerto Rican community people from New York City, who were also in Albany looking for resources, broke up the meeting and accused Dr. Densen-Gerber of "making money off of black and Puerto Rican addicts' misery," Dr. Densen-Gerber's publicity hit its mark, however. Within a few hours Governor Rockefeller called a press conference to say he would pour $265 million (which has since failed to materialize) into services for the teenage addict.

Most recently, community groups have decided to get to the root of the problem: the agencies which handle most of the money for local drug treatment programs—the City's Addiction Services Agency (ASA) and Model Cities. Under the leadership of the city-wide Community Council for Narcotic Programs—which was formed last fall by people running money-starved neighborhood-based programs—has begun to ask what makes ASA and Model Cities run: Who controls the public money for drug treatment and where does that public money go?

ASA directly operates residential treatment programs, does education and counseling, and contracts with private agencies to set up programs. The agency has grown from a staff of only six people and a budget of $400,000 in 1967, to a bureaucracy with over 400 employees and a 1970 budget which exceeds $29 million. It receives its funds from City tax money, the State Narcotics Addiction Control Commission, the Office of Economic Opportunity (OEO), and, most recently, the National Institute of Mental Health (NIMH). Until recently, Phoenix Houses were ASA's only residential program and they followed a strict therapeutic community line. "Not only did most of the treatment money go into expanding Phoenix House (there are now 17 such centers, with six of them being grouped together on Hart Island for prison referrals) but most private treatment programs under contract to ASA were proponents of the same therapeutic community approach.

In the spring of 1969, a new ASA Commissioner, Dr. Larry Bear, took over and began to talk about a "total systems" approach. ASA, Bear said, was willing to try anything to cure addiction: "Methadone isn't the answer to all our problems... but drug availability does have a place, and we've got to use it wherever we can... . We've got to expand our Phoenix House programs... I believe we're on the verge of discovering new techniques that incorporate the best of methadone and the best of therapeutic community programs."

The most diehard therapeutic community buffs within ASA bitterly fought the agency's new tolerance of methadone. Dr. Mitchell Rosenthal, a Deputy Commissioner, who as director of the Phoenix House program held the most powerful position within the Ramirez regime, was carried over to the Bear administration. From his entrenched position, Rosenthal led the fight against the new guard. As head of the Phoenix program, he had a myopic vision of drug treatment and over the years had managed to direct most public resources toward a therapeutic community end. When Commissioner Bear threatened to unload him so that he might install a more flexible Deputy Commissioner, Dr. Rosenthal unabashedly countered: "I own ASA," reminding the Commissioner that he could cripple ASA by shutting down the Phoenix Houses. Some of the carry-over staff adjusted more rapidly to the new, "total systems" approach. For instance, another Deputy Commissioner, Dr. Martin Kotler, assumed a neutral stance, saying, "There are enough junkies for all of us."

Dr. Rosenthal didn't like the readings he was getting from the Commissioner nor from City Hall, however, so he moved to solidify the future of the proliferating Phoenix Houses. Under his leadership, a group of staffers set up a private, non-profit foundation—the Phoenix House Foundation, Inc.—whose ostensible purpose was to bypass the
City red tape in the purchase and leasing of buildings, to manage residents' welfare checks and to solicit private money. The Board of Directors includes not only Rosenthal and some lesser ASA figures, but a heavy sprinkling of prominent businessmen and financiers. Thus, Phoenix Houses are now owned and operated by a private foundation which would not be subject to the program policy whims of a City agency. (This is analogous to the Municipal hospitals in New York City which have been put into a quasi-public corporation outside of City government.)

Officials at ASA were not altogether reluctant to let the therapeutic community folks go their own way. ASA has been hinting for the last several months that they would like to get out of the Phoenix House business and set up an "institute" which would provide training in both drug prevention and treatment to schools, industry and existing drug treatment programs—including Phoenix Houses. Moreover, ASA sees the institute, for which it is actively seeking federal funds, as a national center for training and testing "multi-modality" and experimental drug program designs. The experts already on the ASA staff, they say, would provide an excellent faculty for such an institute. The Phoenix Houses, under such a reorganization, would become contract agencies (through the Phoenix Foundation) just like any other.

Whether the switch in ASA philosophy is politically motivated, or simply an attempt to be more effective, is not clear. But in either case, ASA has been laying the groundwork for a conversion. Last spring it signed a contract with the private Phoenix House Foundation saying if the Phoenix House program should fold, the City would purchase all real estate at market value. It was the City's way of assuring the Phoenix House Foundation that it wouldn't be left in the lurch. Furthermore, ASA has gradually become more centralized, from a time when most of the staff worked in the field to the present with more than half of its staff concentrated in the home office. A glance at the current budget reveals that executive management and administrative positions have increased by $2.5 million and 175 staff positions—while at the same time, money and personal for preventive and rehabilitative positions have decreased in about the same proportion.

While the ASA is fighting over whether the answer lies with methadone or the therapeutic community, community groups are trying relentlessly to extract some money from ASA for their own programs. So far ASA has claimed bankruptcy, and told community groups to go to Model Cities for money, with the assurance that "ASA will back you all the way." One organization represented in the Community Council for Narcotic Programs, the Brooklyn Federation of Independent Agencies, played the game to no avail: "We went to Brooklyn Model Cities and they said we would have to federate because they couldn't deal with a hundred little agencies.

The Model Cities policy committee met (in March) and declared drug programs a priority and allocated $1.8 million to drugs. We submitted a proposal and they said there's no money. They told us, 'You'll have to go to HUD in Washington.' We went, and HUD said, 'Brooklyn Model Cities has all the money and the power that's necessary.' So where's the money? Has it been misappropriated? Where did it go?" If the Federation ever is granted the Model Cities money, they fear that a recent directive that ASA must administer all Model Cities funds for addiction will stall the grant forever. "ASA's OEO money is running out in September—so they have to go somewhere."

In the last few months the militants in the Community Council for Narcotic Programs have let ASA and the Mayor know that they are fed up with inaction. "Officials are always crying for money for the 'communities,' but we never see it," charges Mrs. Elsie Brown, who runs a storefront referral program for addicts in the South Bronx. "Those who are doing relevant work are not given money. It's no accident [that addiction is flourishing]—the power structure wants to drive us out of the City so it can implement its Master Plan [the City Planning Commission's 1970 Master Plan]." The group recently applied pressure on ASA to replace a white regional program director for the South Bronx and Harlem with a black. "Can you imagine?" says Mrs. Brown. "Sometimes they force you to get racial."

This spring, a dozen representatives from the Council seized Commissioner Larry Bear's office and demanded not only that he find money for the communities' programs, but that he do something about the most flagrant abuses in ASA—or resign. The Council complained of the following:

■ Phoenix Foundation: Deputy Commissioner Rosenthal has a conflict of interest as both an officer of the Foundation and as a Deputy Commissioner of ASA. Phoenix House should have to submit proposals like anyone else—on the merits of its program. There is even suspicion that Phoenix Foundation is playing some fast real estate deals. Some houses, it is claimed, have changed hands as many as three times in one day. Even if such fast deals are no more serious than a way to get tax write-offs, the Community Council wants all such deals made public. "Just because the Foundation claims to be 'non-profit'," they say, "that really doesn't mean a thing. It only means that your books don't show a profit—but you could have spent millions in the course of a year."

■ Discrimination in hiring: The ASA brags about getting civil service to accept the concept of hiring ex-addicts and now has a job description for ex-addicts called "addiction specialists." The Council claims the qualifications are just as restrictive as those for previous civil service slots for most blacks and Puerto Ricans: The ex-addict must have graduated from high school (highly unlikely) or have spent five years in a therapeutic com-
Two Treatments: Methadone vs. Therapeutic Communities

Until recently the treatment of narcotics addiction was neither controversial nor a major medical concern. But with the advent of dollars and political rhetoric, treatment tendencies have polarized into two camps: methadone maintenance and the therapeutic community. Both treatment camps view the addict as sick, but they differ in their description of his illness. Methadone enthusiasts view the addict as having a metabolic deficiency disease, requiring replacement therapy with a drug; therapeutic community-backers view the addict as having a personality deficiency requiring a total character reorientation. Both therapies discount the social and political aspects of addiction. Both therapies are distrusted by many black and Puerto Rican community groups.

Methadone is an opiate-type narcotic drug with analgesic (pain killing) effects similar to those of morphine. Although it was developed as a substitute for heroin, methadone resembles its infamous surrogate in many ways. Both methadone and heroin are addicting drugs, which when withdrawn suddenly induce symptoms including restlessness, sweating, runny nose, tearing eyes, nausea, abdominal pain, and craving for another dose of the drug. Both methadone and heroin, when taken intravenously cause a euphoric sensation called a "high," although heroin is said to produce a better "rush" (the brief, intense, apocalyptic feeling that immediately precedes the high) than methadone. Both the "rush" and the "high" are not experienced with either drug, once the user reaches the tolerance level through repeated, large doses.

If these two drugs resemble each other so much, why substitute one for the other? The major reason is that methadone is legal when dispensed as part of a treatment or research program, while heroin is illegal. In addition, methadone is a relatively long-acting narcotic (12 to 48 hours, depending on the dose) compared to heroin, which must be taken every four to six hours. Thus methadone is much more practical for use in a long-term treatment regimen.

Methadone has two uses: (1) opiate withdrawal ("detoxification"); (2) opiate substitution ("methadone maintenance"). The traditional use of methadone has been in detoxification of heroin and morphine addicts. Methadone is of no benefit to patients who are dependent on other drugs, such as barbiturates, amphetamines and alcohol. Detoxification involves placing the addict on a dose of methadone, which is sufficient to prevent heroin withdrawal symptoms, and then gradually reducing the dose to zero over one to two weeks. Though the addict may feel some discomfort during this process, the severe pain and nausea of withdrawal are greatly diminished, if not completely absent. This method has been used for over 20 years at the Public Health Service Hospital in Lexington, Kentucky, and more recently has been offered from outpatient clinics serving ghetto populations. If detoxification is the only "treatment" given, however, chronic, long-term addicts almost always return to heroin.

The failure of methadone detoxification as a "cure" led to the development of methadone maintenance programs. Methadone maintenance involves starting the addict on small doses of methadone, which prevent heroin withdrawal symptoms. Then the methadone dosage is increased over a two to four week period until a toleration level is reached, at which point the addict no longer experiences either the euphoric "high" or the craving for heroin. This level of methadone is subsequently maintained, presumably for life. Methadone maintenance may be accomplished without ever admitting the addict to the hospital. However, most programs prefer
to treat the addict as an inpatient for the first six weeks. Some form of social rehabilitation accompanies most methadone maintenance programs, including job counselling, vocational training, and some psychiatric help.

Methadone maintenance, as a therapeutic program, was developed by Vincent Dole, M.D. and Marie Nyswander, M.D., both of Rockefeller University in New York City. Dr. Dole hypothesized that continued opiate addiction created a metabolic deficiency which could only be treated by replacement therapy (maintenance of opiates or substitutes for them such as methadone). This dovetailed well with the experience of Dr. Nyswander, who had noted that after treatment by all other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving well with the experience of Dr. Nyswander, who had noted that after treatment by all other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit. Although there is thus far little other existing methods, the addict's craving for heroin seemed inevitably to draw him back to his habit.
2205 total admissions to the program, the overall drop-out rate was 18 percent. These impressive statistics are paired with data that indicates a substantial decrease in the number of arrests of program participants, compared with their record prior to entering the program. Also, it is claimed that addiction to other drugs is limited: Fewer than 10 percent of those on methadone maintenance are found to be using amphetamines or barbiturates, and only 11 percent abuse alcohol. Finally, Dr. Gearing reports that none of the patients who remained on the methadone maintenance program has become readdicted to heroin.

These positive results have been extrapolated by program enthusiasts to apply to all addicts. For example, Dr. Harvey Gollance at the Beth Israel program said, "Methadone administered daily in controlled doses would allow 80 percent of all addicts now on the streets to begin self-supporting, normal lives." And Dr. Vincent Dole, who launched methadone, has claimed that "maintained" addicts would have "an 80 percent chance of becoming acceptable citizens." However, serious reservations must be raised about such statements, because of the selective admissions procedures and the voluntary character of the methadone maintenance program. Success may be directly related to the population of addicts who have been primary program participants. They have tended to be male, white and over 25 years of age. From this biased sample, it is difficult to extrapolate to the entire population of addicts (although other programs have reported success with less highly selected groups.)

Even the data contained in the independent evaluation report which is the basis for the "success" statements, is open to question. First, the data collection was not independent of the program. When Dr. Gearing was asked if her committee went out and got its own information, she replied: "The evaluation committee did not go out ... we got our reports of arrests in two places, both from the program and the police. ... Initially we did the employer business. ... We have not done it for some time." Apparently, the primary evaluation data are the unit directors reports compiled from counselors' reports, of whom are employees in the program. Second, the employment data is not so impressive in absolute numbers. Only 88 patients have been in the program for three years, so, (if 92 percent are employed) only 80 patients are employed after three years in the program. Moreover, some of these patients are employed by the program itself; Dr. Gearing refuses to say how many. Thirdly, some doubt is cast on the statement that none of the patients remaining on the program have become readdicted to heroin, since detailed data about heroin usage has not been reported.

Methadone clearly has a place in the treatment of the opiate addicts, probably more because of its legality than because of its "medicinal" qualities. Few would deny the utility of methadone for narcotics detoxifica-

are sexually abused: there is no separation of the young from the old. The few rehabilitation programs that do exist are staffed by instructors and group therapists who have received little or no training. For the 5,000 or so inmates in the 14 separate institutions there are only 4 psychiatrists, 16 psychologists and 78 teachers and vocational instructors. The prison-like atmosphere has caused a large percentage of the addicts to try to escape.

The number of civil commitments fell quickly after the truth got out. Judge Amos Basel in a New York Times interview said: "In the beginning, when addicts were brought before me, I used to give them a sales talk. I used to say that the state program was the best thing for them that had ever been devised. But from the reports I have received, I can't see any difference between this and a reformatory." As bad as it was for the civil commitments, the criminal commitments got even worse treatment. Those committed after conviction for misdemeanors found they had an extra two years tacked on to the maximum one year sentence for misdemeanors solely on the ground that they were going to receive treatment. But for the first year or so they were kept in the same cells as the other prisoners. They received no psychological interviews. Their only treatment was voluntary group therapy run by inexperienced college graduates and which, in fact, were open to anyone in the prison who wanted to attend.

The situation was so bad that the State courts almost declared the program unconstitutional in 1968 for failing to provide even minimal amount of treatment. But the court was dissuaded from cutting the program off only after its first year so as to give it a chance to improve. However, there haven't been any noticeable changes since then. The jail-like atmosphere of the rehabilitation centers has also caused a large number of the counselors to quit in disgust. They find it impossible to conduct a therapeutic program in such a repressive atmosphere [See May 1970 Bulletin.] Rockefeller, in an election year, feels the rock around his neck and has himself criticized the program as a waste of money. In a speech to an interfaith convention of clergymen on drug abuse he said, "I cannot say we've achieved success—we have not found answers that go to the heart of the problem." He told the clergymen that, "It's a goddam serious situation."

The program has failed everyone. It has failed the "clean streets" people because it has handled only an estimated 5 or 10 percent of the state's addicts. And most of those returned from preventive detention have remained addicts. Meanwhile, it has cost over $250 million in taxes or about $25,000 per addict, $1.1 million per "cure" It has failed reformers' expectations because there is no treatment. But worst of all, it has duped the poor addict and his family by incarcerating him for three years on the false promise that it will rehabilitate him.—Ken Kimerling
tion, but many would question the implications of chronic methadone maintenance. Methadone maintenance alone appears to be no more than an attempt at a simple medical fix to a complex social, political, and psychological problem. Social and psychological rehabilitation is also necessary. The therapeutic community has emphasized these latter aspects of the treatment of addiction.

The enthusiasm of the methadone buffs is matched only by that of the therapeutic community devotees. When psychiatrist Daniel Casriel first went to Synanon, he left the drug treatment facilities of an elite New York City medical center, where finances were adequate and staffing was superb. Yet, he had to admit, "I personally felt that I had cured not one addict." After visiting Synanon, the prototype of the drug-related therapeutic community, for several months, his despair had turned to hope: "I am convinced that Synanon holds the solution to the enigma of drug addiction."

Indeed, therapeutic communities like Synanon, Daytop Village, Phoenix House and Odyssey House are impressive counter-communities, especially when compared with the street-life of the addict, or even the normal day-to-day life of the average suburban American. Within the therapeutic community, there is allegedly an honesty, openness and truthfulness about interpersonal relationships that cuts through the alienation and loneliness of modern society. It is not surprising that Synanon has even attracted a large following of non-addicts ("squares"). But this superficial similarity to the hippie commune breaks down under a more careful dissection of the therapeutic community.

All drug-related therapeutic communities share the same concept of the addict: The addict is emotionally disabled by his family background and present behavior, in such a way that he feels insecure, inadequate, scared, lonely and isolated from normal society. To treat the addict requires focussing on the emotions that drive the addict to the needle. Therapeutic communities are designed to provide this type of care through three mechanisms: (1) encounter group therapy, a specific mode of psychiatric therapy; (2) a highly structured community; (3) a reward-punishment system based on simple behavioral psychology.

The key to the therapeutic process is the group encounter, variously called the Synanon game, attack-therapy or the "verbal street fight." Usually, encounter groups are comprised of 12-15 participants, who change each session. The procedure involves singling out an individual, whom the rest of the group questions, cajoles, accuses through any manner of violent verbal confrontation. The addict is caught in his lies and manipulations and is forced to confront his present behavior and even his self-image. One addict describes the power of the encounter this way: "If a man tells you you're a horse, he's a liar. If two people tell you you're a horse, it's a conspiracy. If everyone in the room tells you you're a horse—brother, go buy a saddle." These encounter sessions may last three to four hours, but occasionally, when the group is "loose" (for example, when many new members have entered the group) a marathon session is held, which may last for 36 or 48 hours. In most therapeutic communities, encounter sessions are leaderless, and doctors and psychiatrists are explicitly excluded. Ex-addicts play an authority role, conferred by experience and not by academic degree, by calling down any new addict who tries to "con" the group.

This does not mean that therapeutic communities are egalitarian. On the contrary, they are very hierarchical, precisely because status within the community serves as a major form of reward. Among addicts, this is manifest by the strict and ordered phases required for graduation from the program. The form of these phases is the same in each program. First, during the induction phase, the addict's motivation for entering the program is tested. He must wait hours at the induction center, attend trial workshops or encounters, dress neatly, and gradually withdraw himself from heroin. This phase may take from two weeks to six months, after which the addict may be accepted as a fulltime resident of the therapeutic community. Then, phase two begins, the treatment phase. During this phase, the addict undergoes complete behavioral dissection through encounter therapy and a scaled program of house jobs, which start with dishwashing and progress to ordering supplies and leading group therapy sessions. This phase lasts from one to two years, with increasing responsibility given to the addict for the operation of the therapeutic community. Finally, the third or re-entry phase is embarked upon, in which the addict progressively exposes himself to the world external to the therapeutic community. After six months to one year, this last phase is brought to a conclusion with the now ex-addict taking up employment in the expanding program of his therapeutic community or (less frequently) taking up fulltime employment unrelated to addiction problems. This careful staging for the addict of higher levels of status within the program is usually not achieved without some setbacks, with the staff deciding when the addict will be demoted or promoted.

The ultimate arbiter of these decisions, in most therapeutic communities, is the director and his staff. In effect, when entering a therapeutic community, the addict accepts a small power of decision over his life, except the decision to leave. The director decides when he can go on pass; start dating a girl; and what job he gets. Though not differentiated by dress (directors dress like residents), the distinction between residents and directors is clearly maintained in terms of authority. As one observer of the Phoenix House program said, "The residents make mistakes. The directors don't." The presumed function of this hierarchy, in which ex-addict-staff member dominates the resident, is to provide an incentive toward becoming a director—the role-model of the ex-addict.
In its simplest sense, treatment within the therapeutic community is a form of behavioral psychology. The resident-addict is rewarded with status for good behavior, such as honestly examining his motives within group sessions and taking on responsibility within the community. On the other hand, the resident-addict is punished for acting out negative feelings and failing to take on responsibility in the community, by tactics ranging from verbal torture within the encounter session to head-shaving and loss of status within the hierarchy of the community. These rewards and punishments are meted out on the basis of a stringent set of norms: (1) no drug utilization within the community, including alcohol; (2) no physical violence; (3) no homosexual relationships, and initially no heterosexual relationships; (4) no escapism in any form, such as “tripping” (daydreaming) or “bad-rapping” (criticizing) the program; (5) masculine roles for the men—both leadership and physical work roles, and trad-

ALCOHOL
- 80 million Americans consume some alcohol every year.
- 6 million Americans are alcoholics and several million more have severe drinking problems.
- 1968 per capita consumption: liquor—2.4 gallons, beer and wine—27.5 gallons.
- Alcohol Sales: liquor—$10 billion, beer and wine—$9.735 billion per year.

CIGARETTES
- 80 million Americans smoke cigarettes.
- 1968 consumption: 570.7 billion cigarettes.

PRESCRIPTION DRUGS
- More than one half of all Americans take at least one prescription drug per year.
- 10 million persons use prescription sedatives and stimulants.
- 500,000 people abuse prescription drugs (Federal Bureau of Narcotics figures).
- Aspirin production has increased by ½ since 1960. Tranquilizers production has increased by ½ since 1960; Vitamins production has increased by almost ½ since 1960.
- Drug sales at manufacturers’ levels, 1967: Barbiturates-$2,078,000 Tranquilizers-$4,658,000

Addictive docile and subservient roles for the women, such as cooking and sewing. In essence, fundamentally middle class norms of abstinence and puritanism are imposed on the addict with an almost religious fervor.

All of this is justified on the basis of the addict as a sociopathic personality, who must be turned about 180 degrees. Addicts are not just wedded to their habits by the craving for a high and the pain of withdrawal. Addicts have a life style which gives them an identity and a vocation, in contrast to the meaninglessness of their younger life. “How do you cope with a situation where a man is able to get a profound sense of being of some value, which is what you find in the drug world?” asks one director. By becoming a surrogate family, the therapeutic community seeks to substitute a new identity, a new group to belong to, and vistas of a new vocation for the addict.

Therapeutic communities for drug addicts have sprung up all over the country. The major trend setters include:
- Synanon was started by Charles Dederich, an ex-alcoholic in California. Synanon (a word coined by a member who slurred the word “seminar”) has grown into an organization with over $8 million in assets, including real estate, hotels, gas stations, etc. and with eight offices from Santa Monica, California to Puerto Rico. Recently, Synanon has moved away from mere treatment of addicts and alcoholics. For instance, the San Francisco branch has 200 residents (largely ex-addicts) and also 1,250 “squares” who are not residents yet, but participate in the Synanon “game” (encounter sessions). The directors now maintain that Synanon is not set up to cure dope addicts, but rather is a social movement that offers its residents “a way of life that is not futile.” Dederich explains, “The rest of society is a mess. . . I believe it is beyond reform or change and so we’re trying to create a community where people live and flourish. It’s not a political movement, even though some politicians are afraid of us; it’s more like a religious movement. We’re not out to get people’s votes, we want their minds.” Hence, Synanon does not attempt to reenter its members into society, but rather tries to maintain their dependence on the Synanon organization, by providing jobs, meaningful life style.
- Daytop was founded by former Synanon ex-addict David Deitch and Synanon enthusiast, Daniel Casriel, M.D., in 1963 in New York City. It grew rapidly into four centers in the New York metropolitan area with an annual budget over $1.5 million. Like Synanon, it used ex-addicts as the primary therapists. Unlike Synanon, it emphasized reentry into society. In fact, it was a fight over this reentry program, one in which Deitch tried to train addicts as political activists to change their communities, that resulted in a major split within the program. Deitch was forced to resign and Daytop’s program has not introduced any innovations since.
- Odyssey House was started by a group of ex-addicts and Dr. Judianne Denson-Gerber. They were part of a cyclazocine drug maintenance program at Metropolitan Hospital and decided to switch to a therapeutic community treatment model. Since 1967, Odyssey House has grown to include seven units. Though prominent for its concern for the adolescent addict, only one of these units focuses on this age group. Odyssey differs little from Synanon and Daytop, except for the prominent role of the professional therapist. In defense of this practice, Dr. Denson-Gerber points out that many addicts feel they want to talk about their problems with a highly
trained expert rather than a former addict. Ex-addicts are employed within the program, but their function often serves the needs of the professional. Together with the residents, ex-addicts assume responsibility for enforcement of house rules, so that “the psychiatric staff can devote fulltime to treatment rather than enforcing police or security methods. Thus they are maximally able to utilize their training with minimum waste of effort, talent or money. This prevents much of the frustration and depression often seen in professionals who treat addicts.”

Phoenix House is the therapeutic community program of the Addiction Services Agency of New York City and is the largest therapeutic community program in the country. It was founded by Dr. Efren Ramirez, a Puerto Rican-born existential psychiatrist. This program has grown to include nine centers and over 900 addicts in treatment. It differs from all previously described programs, in that it has a high percentage of addicts under criminal certification, who are not involved in the program on a strictly voluntary basis. Thus, the Hart Island facility which houses six of the Phoenix House centers resembles a detention center more than other therapeutic communities.

No independent investigation has been done to judge the effectiveness of the therapeutic community approach. But it is clear that claims of success do not tell the whole story. Daytop boasts 85 percent success based on the number of ‘clean’ graduates; Odyssey claims 71 percent success based on the number of addicts who stayed clean for one and a half years, including those still in the program. Yet, after three years Phoenix House, Daytop and Odyssey together had fewer than 140 graduates. Also, Phoenix House(s) have only 950 enrollees rather than the predicted three year enrollment of 25,000 addicts. Perhaps this is because only three percent of all addicts volunteering for treatment choose the therapeutic community. And after joining the program, the drop-out rate is over 80 percent on the average. Most of those who leave, do so in the first 30 days, and inevitably return to the needle. Of those who leave after six months, more than one-half shoot up again. Some say it is too early to make definitive conclusions about the effectiveness of the therapeutic community, but certainly the initial data are not impressive.

The therapeutic community can also be criticized for incomplete reentry of its residents into the community. Therapeutic communities do not appear to make people independent. By providing a life that is better than real life, ex-addicts get “hooked on the community” rather than on heroin. This becomes only another form of dependency. Over 50 percent of all ex-addicts that graduate from therapeutic communities are reemployed within similar programs relating to addiction. On the one hand, this result derives from the rigid reward and punishment system laid down by the therapeutic community. The most successful people are those who are articulate and capable of taking leadership within the community. Other forms of personality expression are not encouraged. On the other hand, there is very little educational emphasis within the therapeutic community. Ex-addicts are not encouraged to go to school during treatment, since that would interfere with the therapeutic process.

From black and brown communities, there comes a barrage of criticism of the therapeutic community. Blacks are angered at the personality and identity destruction that goes on in encounter therapy. They feel that blacks have been stripped of their identity by white society long enough, and that the emphasis should be placed on building black identity. Puerto Ricans point out that all encounter groups are usually carried out in English, so that the Spanish-speaking person is always at a disadvantage. The pervasiveness of middle class values as the norm for the therapeutic community also negates the past, present and probable future of most black and brown addicts. Middle class values just don’t apply in the communities these addicts are expected to return to.

The therapeutic community tends to reduce drug addiction to the level of an individual problem. This position derives from the concept of the addict as a sociopathic personality. If on the other hand, addiction is attributed at least partially to a sick society, then its cure is to involve the ex-addict in changing society. Several groups have taken this position. The Community Thing is a Harlem neighborhood group that unites around the issues of black pride and self-help. They keep the addict in his community and teach him to be functional there. David Deitch, an ex-addict, was fired from Daytop when he proposed a similar program, called GUTS (Guerrilla Urban Training Satellites), which was supposed to train addicts to return to their communities as political activists.

In conclusion, both methadone maintenance and the therapeutic community can expect to come under increasingly severe community criticism. As more money is poured into therapeutic programs, with little visible effect on the community, the question of who is really benefiting from addiction therapy will be raised loud and clear. Black and brown communities are going to want a greater role in shaping the programs that serve their communities, particularly programs with such great social control potential as addiction services programs. [The above article was prepared by a HEALTH-PAC Workshop on Drug Addiction with Special research assistance by Harriet Block, sociologist and member of the New York Medical Committee for Human Rights; and Lester Wallerstein, a graduate student in psychology at New York University.]