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Miss Diana Clarkson
Executive Secretary
California Interim Committee on Public Health
Room 414, Earl Warren Hall
University of California Campus
Berkeley 4, California

Dear Miss Clarkson:

In response to your request for my views on the medical aspects of narcotic addiction, methods of treatment and their effectiveness, etc., you are advised that this is a large order that cannot be well condensed into a letter because it is intimately bound up with the gross distortion of the narcotic problem worked up throughout the years by uninformed, mostly non-medical persons, who have been so loudly and persistently vocal that even many physicians who have not specifically studied addicts have been misled by the propaganda.

I believe you have my SATURDAY EVENING POST article. I am, however, enclosing a copy of it and a copy of another article, The Drug Addiction Muddle, which may be of interest to the Committee.

You should have a copy of the Report on Narcotic Addiction, recently made by the Council on Mental Health of the American Medical Association. Write for this to Richard J. Plunkett, Secretary, Council on Mental Health, 535 North Dearborn Street, Chicago 10, Illinois. This is a comprehensive report made by a group of experts after careful study.

Also get from the British Library of Information, 45 Rockefeller Plaza, New York 20, New York, a copy of D.D.101 (6th Edition) February 1956, entitled The Duties of Doctors and Dentists under the Dangerous Drugs Act and Regulations. Send 20 cents for this to Account, British Information Services and be sure to read pages 14, 15 and 16.

This should dispel the misleading statements frequently made by some narcotic enforcement people here that the British method does not differ from ours. The British method is more elaborately explained by Alfred E. Lindesmith in LAW AND CONTEMPORARY PROBLEMS, NARCOTICS, School of Law, Duke University, Vol. XXII, No. 1, Winter 1957. Write for this to Law and Contemporary Problems, Duke Station, Durham, North Carolina. The price is $2.00. The volume contains other articles on drug addiction, including one on treatment.

With these preliminary remarks I follow with the following brief statements about the effects and treatment of narcotic addiction.

Addiction to opiates such as morphine and heroin is a serious and distressing problem for anyone so addicted. The most serious part of the problem is that such addicts must have their dose three or four times daily to prevent what is at time intense distressing sickness, the so-called withdrawal symptoms. Practically all such addicts want to be cured and should be given opportunity for cure.

Addiction does not cause mental, physical, or moral deterioration if the addict is able to get regularly and cheaply the needed supply of morphine or heroin. The taking of large daily doses, 20 to 60 grains, is somewhat harmful; but for purposes of comparison the harm is not nearly as great as that done by alcohol to many drunkards.

Addiction to morphine and heroin as now managed is harmful because of police harassment, inadequate and irregular supplies with resultant sickness, high price of drugs in the illegal market resulting in inadequate food, and the more or less criminal associations and practices that the addict is forced into in order to avoid the abstinence sickness.

Up to 20 grains of morphine or heroin daily does not decrease the capacity or inclination of addicts to work. Larger doses cause a slight slowing up but I have seen 30 or 40 grains-a-day addicts who worked regularly for years.

Neither morphine or heroin, regardless of the size of the dose, cause anyone to commit aggressive crimes. The effect is contrary to this but large doses such as some psychopaths and highly neurotic addicts would take if available to them, cause an indifference that may lead to occasional less serious crimes.

The chronic addicts in this country are practically all recruited from unstable, emotionally involved people. Some of these were more or less serious criminals before they became addicted. They commit less crimes when under the influence of morphine or heroin and more when deprived of the drugs. Many of the other unstable primarily emotionally involved addicts commit crimes to support the habit that they would not commit without the habit or if allowed to legally support the habit.

Heroin is grain for grain more toxic than morphine but no more harmful to addicts than morphine and other addicting opiates. There is no scientific evidence whatever to support the popular idea that heroin has special sinister properties.

As to the results of treatment -- drug addicts can be cured and thousands have been cured. Many of them relapse after treatment and may be permanently cured after several treatments. Many of them never achieve cure.

The degree of success in cure depends on how emotionally involved the patients are. The reason there is so much relapse now is that most addicts are seriously involved in the first place; the less seriously involved are eliminated by cure leaving a chronic relapsing group who return often for treatment and give an exaggerated impression of the difficulty of cure. This latter group is comparable in probabilities of cure to the skid row alcoholic.

The drug, of course, must be withdrawn and the best way to do this is by the Lexington method which I will not go into here. You can get it from articles written by the Lexington research group.

After withdrawal the patient should be kept around for approximately 4 months and maybe longer, during which time, work, recreation, library facilities, other activities, and at least group psychotherapy should be available to them.

Treatment about like this is given at Lexington. It is designed to adjust the person to living without narcotics and help him understand himself. After hospital treatment the patient should be followed, never by police, but by some social worker arrangement working from a psychiatric clinic in San Francisco and Los Angeles where some psychotherapy might be done and assistance given in securing

employment where necessary. If the patient relapses I would send him to the hospital again and again. When the case after numerous failures seems hopeless, I would handle him in the way to be described for chronic apparently incurable addicts.

California does not have sufficient narcotic problem to justify the establishment of a special narcotic hospital. The State mental hospitals can be used though admittedly they are not ideal places for treating addicts. Addicts should be allowed to go to the State Hospitals voluntarily if they desire. If such patients demand release within a period short of that deemed necessary by the superintendent he should be committed by court order. He should be re-admitted as a volunteer if he is discharged after what is considered adequate medical treatment and then relapses. He should not be hounded by the police. In fact, the hospital narcotic records of volunteer patients should not be open to the police.

An alternative method would be for the State or municipality to pay the fare necessary to get a volunteer patient to the U.S. Public Health Service at Fort Worth where more satisfactory treatment can be given.

State patients cannot be committed to the Government narcotic hospitals, nor can the hospitals force a voluntary patient to stay or notify the State if he leaves. Nevertheless, if such patients do leave against medical advice and the fact becomes known, they should be picked up and committed to a State hospital.

The addicts now sent to jails in California because they are addicts should, in my opinion, be committed to State hospitals. The jail is no place to rehabilitate an addict.

I would select one State hospital in the north and one in the south for the treatment of addicts so that more interested staffs and more efficient methods would develop than if only a few patients are scattered in all the hospitals.

As to the treatment of addicts in State hospitals, they, like the alcoholics, will be benefitted if they stay there for a prescribed time, and take what the hospitals have to give. Some of them will be permanently cured. It is a mistake to assume that elaborate psychotherapy or

psychoanalysis is needed. It is also too broad a statement to say that ambulatory treatment at home will not be successful although such treatment is certainly not the treatment of choice for patients still taking narcotics.

For these patients who apparently cannot be cured, the chronic cases previously referred to, I would adapt the English regulation which provides that narcotics may be dispensed to an addict when "it has been demonstrated that the patient, while capable of leading a relatively useful and normal life when a certain minimum dose is regularly administered, becomes incapable of this when it is entirely discontinued." The Council on Mental Health of The American Medical Association speaks favorably of this regulation. It would, of course, require a change in the law.

The attitude of the law and narcotic administrators towards doctors should also be changed. Of the thousands of doctors in this country who have been sent to the penitentiary and had their license to practice revoked because of narcotics, not more than 10 per cent had done anything more serious than give narcotics to patients who desperately needed them. In England at least 90 per cent of that 10 per cent would have had nothing done to them but their liberty to prescribe narcotics revoked.

Before closing this discourse about opiates I will show by illustration that even a doctor who prescribes for dying patients is not safe. Last year I testified in court as an expert involving a physician who prescribed methadone in moderate doses for four patients. Fearing that they could not send this man to the penitentiary for treating these patients, the police arranged with one of the patients, whom they at first arrested, to assist in an ingenious entrapment of the doctor for at least a technical violation of law. They then arrested the doctor, advertised him as a narcotic racketeer and had him indicted for this technical violation and on four other counts for prescribing for the four patients, not in good faith in the course of medical practice. Three of the patients are now dead and one is in a mental hospital for a condition not caused by the methadone.

This case illustrates that physicians who try to relieve or save the life of patients by giving them a needed narcotic are in an extremely hazardous position. One who reads page 17 of the generally excellent report on

Narcotics Addiction to Attorney General Edmund G. Brown (1956) and finds there the statement which implies that 32,000 addicts in California are being legally carried by doctors may doubt the hazard. But the statement, page 17 of the report proves my contention and illustrates the point I have made. I don't know the actual cause of the statement but from actual knowledge of what happens all over the country this can be deduced. Throughout the country narcotic inspectors snoop into cases where a doctor has found it necessary to give a narcotic for several days. In California there have doubtless been 32,000 such cases and some not well informed person put all of these cases down as addicts when, as a matter of fact, probably only a few hundred received a narcotic regularly and these were extreme, suffering and dying people. This California report contains another and greater absurdity but I will not bother you with it.

Addiction to the two synthetic drugs demerol and methadone has practically the same effect and should be handled the same as addiction to opiates.

I do not have time to go into a detailed discussion of marihuana. You will find it discussed briefly in my POST and POLICE JOURNAL articles and by an extract enclosed herein from a letter I wrote to an inquirer two months ago. Marihuana addiction is easier to treat than opiate or serious alcohol addiction.

I hope the committee may find this material useful.

Sincerely,

Lawrence Kolb, M.D.

Enclosure