

August 28, 1969

Miss Eleanor E. Carroll
Acting Chief
Center for Studies of Narcotic
and Drug Abuse
National Institute of Mental Health
5454 Wisconsin Avenue
Chevy Chase, Maryland 20015

Dear Miss Carroll:

Your questions of August 25 are most interesting, and some I can answer immediately.

I use cannabis as the general term for the plant species and products to include marijuana, hashish, and their extracts, as the cannabinoids. In a broad sense, the word can also "cover" the synthesized tetrahydrocannabinols, if we assume these to be related to the active principle of the plant.

1. Strength of cannabis. Two problems are involved - the cannabis used by the subjects for years, and their present samples. Dr. Miras has assayed samples for some years now and we will depend on his estimates of the quality available historically. I expect that direct assays of the subject's present materials will be done. I do not know if a history of cannabis quality during these decades can be compiled, but we can attempt this. I will bring your question to Dr. Miras' attention.

2. Definition of "Chronic". In Dr. Miras classification, we are focussing on the B, B-C and C groups. The initial step in the project is to identify the population and assess their reports of cannabis use. The subjects introduced to me claimed daily hashish use since their early adulthood, approximately 20-30 years. We will examine as many as we can and report their statements. "Chronic" will be defined by these records.

3. Sample size. Dr. Miras speaks of 200-300/subjects in Athens. We would survey as many as we can, and study in detail 30-40.

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4. Drug use forms. I will write to Dr. Miras requesting a copy of his form. The DCMH form and our cannabis inventory (derived from Haertzen) are enclosed.

Dr. Miras' classification does have "overlap", and he emphasizes the fluidity of subject's use, allowing him to classify subjects as A/B or B/C. Perhaps we will be able to define these classes more satisfactorily. I expect it to be difficult since it is likely that the reports by each subject will fluctuate widely depending on their trust in us. Our experience with opiate addicts may be useful - for we usually disregard the reports given initially, and depend more on their later reports.

5. Sibs and family members. Yes.

6. Volunteers. We wish to bring some subjects into the hospital for testing; allow them to smoke their products; and examine them for 24-48 hours (or longer) thereafter. To induce their cooperation, we will pay them for lost income plus a bonus for volunteering (plus, on occasion, money to buy their hashish in quantity sufficient for trials and for assay). If we get 30 subjects, it averages \$100/subject. This may be too high, but we can report our exact costs and return any balance of the requested amount.

7. "Hashish". In my initial interviews, I was impressed that the men claimed not to use alcohol or opiates. We are interested in drug "associations" and synergistic uses - and will inquire, not only for their present use, but their historical use as well.

8. Anthropological, Sociological Consultation. This is a defect in the present proposal which may be remedied. I am asking Dr. Feldstein to make the first examinations, and he is aware of this issue. I have written to Dr. Miras about this question, and he has yet to answer. You will note I request funds for 2 consultants, and have named only one (A. M. Freedman). I would like to consider, once our initial data is collected, to ask Richard Brotman of the New York Medical College to assist us.

Some forms are enclosed. The rest will follow as received.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry

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