A STATEMENT CRITICAL OF CURRENT LEGISLATIVE PROPOSALS DEALING WITH THE NATIONAL PROBLEM OF DRUG ADDICTION

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In the opinion of psychiatrists, several legislative proposals now before Congress to tighten control of illicit traffic in drugs, chiefly by increasing penalties for possessing and selling them, represent backward steps in attacking this national problem. It is noted that public hearings on these particular bills (S. 3901, S. 3760 and H. R. 11106) have not been held, thereby giving professional opinion an opportunity to take exception to them. Although these bills differ in many details, considered as a composite they have the following effects:

They drastically increase penalties attached to possessing and selling the drugs, in one case providing the death penalty for a third conviction.

They provide for mandatory jail sentences, and in doing so substantially discourage or abolish previous flexible provisions for parole, probation, and assignment of offenders to Federal hospitals for treatment and rehabilitation.

They discourage the seeking of voluntary treatment by addicts by making it mandatory for a physician in a Federal hospital, including V.A. hospitals, to report such patients to public authorities, thus violating medical confidence. This would apply even to those who become addicted accidentally in connection with a prolonged physical illness.

The bills in establishing punitive measures do not distinguish between "pushers," "peddlers," and high level "operators" in the illicit drug trade.

The bills tend to substitute extreme punishment and police power for a constructive medical program for treatment and rehabilitation of drug addicts that has slowly developed over the years in the Federal hospitals at Fort Worth, Texas, and Lexington, Kentucky, and also in State and City hospitals.

Such legislative proposals apparently arise out of widespread public misconceptions about the nature of drug addiction, drug addicts, and what constitutes a long term constructive approach to the problem from a medical point of view.

The main point to be made is that drug addiction is due to a psychiatric illness, in the nature of a personality and character disorder. The drug addict has approximately the same mental characteristics as the alcoholic and the barbiturate addict.

There are some 60,000 drug addicts in the United States. This is an alarming figure, but from a psychiatric point of view, it suffers by comparison with an estimated 3,000,000 confirmed alcoholics, not to mention some 750,000 mentally ill people found in our mental hospitals on any day of the week.

The notion that a drug addict is in fact a criminal is false. He is made a criminal by law, rather than because of the effects of the drug. Opium and its

derivatives, heroin and morphine, do not as such have the effect of motivating a person to commit crimes. On the contrary, they have a sedative effect and give the addict a sense of being at peace with the world.

It is during the withdrawal phase, when the drug wears off, that the addict is impelled to criminal behavior. His motivation is simple and direct: to get money to purchase more of the drug, without which he suffers extreme pain and discomfort. His crimes are not generally crimes of violence such as rape and murder. Rather, they are crimes of stealth, petty thievery, picking pockets, breaking and entering, and the like.

Alcohol, on the other hand, does have some crime producing qualities, notably by way of stimulating people to socially irresponsible action. It is estimated that seven out of a hundred fatal automobile accidents, for example, are due to the influence of alcohol. It is commonly believed that criminals become "hopped up" on the drugs to commit crimes. This is not so. They are far more apt to take alcohol to work up courage and confidence to commit the crime.

Marijuana, taken in sufficient quantity, may have certain crime producing qualities. Studies, however, indicate that crimes committed as a result of taking marijuana are relatively rare, and usually occur when the drug is used in conjunction with alcohol.

There is also wide misunderstanding about terms used in connection with drug addiction and the traffic in drugs, notably the terms "peddlers" and "pushers." The peddler is himself usually a drug addict. He obtains and sells the drug to other addicts as a means of obtaining his own supply. Most peddlers are not concerned with selling drugs to non-addicts or with promoting drug addiction.

The "pushers," however, for the most part are non-addicts who are key agents in the network of criminals who seek to promote drug addiction among the population for the profits that are in it. Some drug addicts, it is true, become "pushers," but the bulk of them do not.

It is also common knowledge that there is a select group of "big time operators" at the top of the drug trade hierarchy who make huge profits yearly out of supplying the drugs to sick addicts and in promoting drug addition generally. They are the arch criminals of the trade, and Federal legislation to date has been notably unsuccessful in putting them out of business.

By not distinguishing among peddlers, pushers, and big time operators in prescribing punishment, these legislative bills make it impossible to provide treatment and rehabilitation for the peddler addict.

It seems clear the root of the evil lies in the profits that are available in the illicit drug trade. The situation is somewhat similar to the kind of profiteering and gangsterism that characterized the illicit liquor trade in the 1920s. In the long run a method must be found to remove the profits. There is no reason to believe that extreme punishment for peddler addicts will help. Indeed, to the extent that such legislation discourages further treatment and rehabilitation for them, it may be expected to worsen the situation.

A sound medical program designed to make substantial inroads against drug addiction calls for the same essential ingredients as any other medical program: more treatment, more rehabilitation, more research, and the personnel and facilities

to make these possible. Considerable progress has been made in recent years in Federal, State and City hospitals in treating and rehabilitating addicts. The incidence of drug addiction has decreased over the past thirty years. This progress has been made under rigorous existing legislation and procedures (The Harrison Act). The medical assumption may be made therefore, that further headway can be made by elaborating the treatment and rehabilitation programs that have already been started.

Much more, of course, remains to be done; but progress lies in the direction of expanding the medical attack on the problem. It is possible to envisage the gradual development of a medical approach that would not only become increasingly effective in reducing drug addiction, but would at the same time take the profits out of the illicit drug traffic. Many proposals for making possible the prescribing of drugs for addicts under medically controlled conditions have been considered and recommended in medical circles. These proposals should be subjected to careful investigation and experiment.

Additional legislation concerning drug addiction should be directed to making further medical progress possible, rather than discouraging it. The legislative proposals now under consideration would undermine the progress that has been made and impede further progress. Thus, they are not in the public interest.

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