In the Packet - of White House Conference 1960

Prevention and Control of Narcotic Addiction

U.S. TREASURY DEPARTMENT

BUREAU OF NARCOTICS

WASHINGTON, D.C.

1960

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Foreword

This booklet was prepared for several reasons. It throws light on the highspots of the history of narcotic drugs—how they have served in medicine—also how abuses have arisen and how they have been handled at home and abroad.

Recently discussion has come up about creating clinics which would legally dispense narcotic drugs for addicts. This subject receives some careful analysis.

Then the booklet presents the two principal ways for effective handling of illegal phases of narcotic activities—namely (1) compulsory hospitalization of the addicts and (2) adequate legislation and policing.

It should be kept in mind that many narcotic drugs, when properly used, have great medical values. For instance, they relieve pain resulting from disease or accidents. They are helpful in treating respiratory infections. They have proved useful as sedatives in cases of mental and anxiety stress.

The booklet deals with the abuses of the drugs and how to handle such abuses. While the historical background naturally refers to opium, cocaine and morphine, dangers in recent years have also arisen from narcotic drugs not directly of natural origin, including the synthetics. Today a great many drugs, entirely synthetic in origin, have been discovered. In fact, it is illegal in the United States to import manufactured narcotics. Now, then, for a few historical notes leading up to the present day.

Historical Background

Some 5000 years before the birth of Christ, people in what is now Iraq recorded the earliest known information about narcotics. The great Greek physician, Hippocrates, in the fourth century B.C., recommended white poppy juices for a variety of illnesses. Early Egyptians and other advanced peoples of those faraway times also knew about some of the important medical values of narcotics.

The Spaniards while conquering and exploring Latin America noted that the natives were stimulated by chewing the coca leaf—from which cocaine later derived its name.

But no one seems to have sounded an impressive alarm about unsound handling of a useful narcotic drug until the 18th century when a Chinese emperor, Yung Chen, prohibited the smoking of opium. The imports of opium into China had grown into a big business as addiction became widespread. But Chinese addicts paid little or no attention to their emperor's command.

In America, a trickle of narcotics started coming to our shores even before the founding of the Republic. In the latter 1800's the volume began to swell. Just before the war between the States, the hypodermic needle arrived on the scene. For a while patients were encouraged to buy this new device and apply it on a do-it-yourself basis. Also "panacea" medicines, containing easily obtainble narcotics and claimed to cure almost anything, started to spread over the Nation.

By the time the war in the United States ended in 1865, many thousands of soldiers had received numerous injections to relieve their suffering from wounds and sickness. Some of these veterans began to rely on addicting drugs.

Then, with the growth of advertising, which in those days promoted patent medicines containing narcotics, many persons who took such medicine became dependent upon it. Later they often found out about the specific narcotic ingredient and started using that. Passage and enforcement of the Federal Pure Food and Drug Act in 1906 helped to relieve this particular situation.

But the medical profession and various molders of public opinion had become apprehensive of misdirected employment of narcotic drugs. It was known that adult addiction had spread and was gaining, especially among women. Also, in the early 1900's there was a great increase of teenage heroin addiction.

HISTORY OF NARCOTIC ADDICTION IN THE UNITED STATES

Thousand Addicts

200
180
160
140
120
100
80
60
40
20
0

1900 1905 1910 1915 1920 1925 1930 1935 1940 1945 1950 1955 1960

1 out of 400 persons addicted

Harrison Act

Cause of Addiction 1900–1915

1. Chinese Opium Smoking.
2. Civil War Opium Eaters.
3. Invention and Use of the Hypodermic Needle.
4. Opium, Marihuana and Heroin Freely Available.
5. Heroin introduced as cure for Morphine.
6. Opiates as cure for Alcoholism.
7. Opium Content of Patent Medicines.
8. Opiates only Analgesic Available.
9. Laudanum.

Traffic Supplied By 1900–1915

1. Free legal sale of manufactured drugs.
2. Chinese, Persian and Indian smoking Opium (Small Tax).

Characteristics 1900–1925

1. Heavy habits: 2 to 10 grains per day, some 20 to 40 grains.
2. Many cocaine users.
3. Opium smoking common.

Traffic Supplied By (1920)

1. Doctors.
2. Illegal Purchases from Pharmacies.
3. Official Clinics.
4. Diversion from Factories and Wholesalers.
5. Far and Near East Opium.
6. Peruvian, Bolivian and Japanese Cocaine.

Addiction 1900–1945

Predominantly Caucasian and Chinese.

Traffic Supplied By 1920–1940

1. Imports from manufacturers in Switzerland, Germany, France, etc. (smuggling).
2. Production of Japanese Heroin and Morphine factories.
3. Rx forgeries and wholesalers diversion.
4. Small drug store larcenies.
5. India, China and Near East Opium.
6. Limiting of manufacture to world Medical needs puts accent on clandestine factories in Europe and Near East.
7. Clandestine manufacture of Heroin and Morphine in Europe and Near East.

Characteristics 1925–1940

1. Light habits.
2. Cocaine disappears.
3. Five male to one female.
4. Opium smoking on wane.

60,000 addicts 1936 1 in 2,100 addicted

Cause of Addiction 1945–1958

1. Italian heroin diversion.
2. Chinese Communist traffic.
3. Turkish, Lebanese, Syrian and Italian heroin.
4. Light Penalties (Heavy penalties enacted 1956).
5. Peruvian cocaine diversion 1946–1948.
6. Reduced enforcement (F.B.N. Training School established 1956.)
7. Juvenile delinquents.

Traffic Supplied By 1940 to Date

1. Turkish, Lebanese, Syrian, Chinese, Italian and French Heroin.
2. Mexican heroin (California).
3. Mexican opium.
4. Drug store robberies, thefts and Rx forgeries.

Characteristics

1. 1946 to 1950, fairly heavy habits.
2. 1950 to date, very light habits.
3. 1946 to date, heroin addiction predominates.

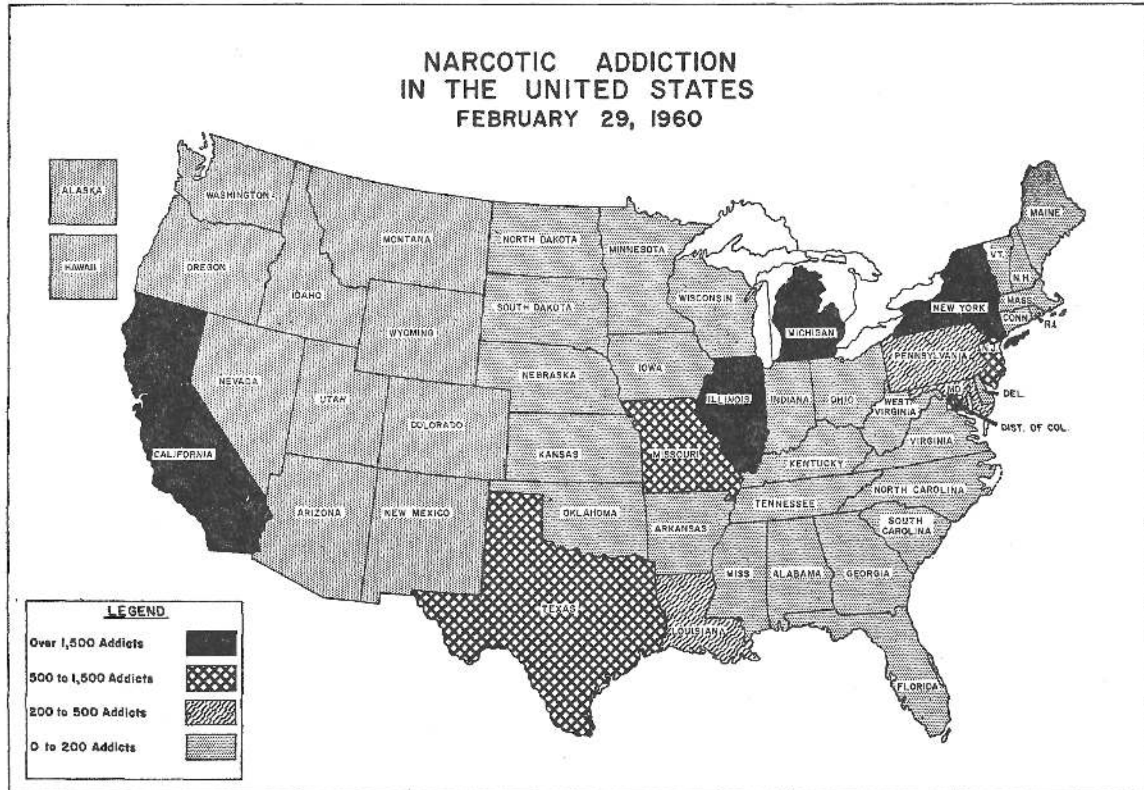
Boggs Act

1 in 4,000 addicted

1. Narcotic Control Act (1956)
2. Increased enforcement programs of local police in major cities.

Addiction 1945 to Date

Majority Negro and Puerto Rican. Chinese disappearing.



NARCOTIC ADDICTION
IN THE UNITED STATES
FEBRUARY 29, 1960
ALASKA
HAWAII
WASHINGTON
OREGON
CALIFORNIA
NEVADA
IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICHIGAN
INDIANA
OHIO
KENTUCKY
TENNESSEE
MISS.
ALABAMA
GEORGIA
FLORIDA
SOUTH CAROLINA
NORTH CAROLINA
VIRGINIA
WEST VIRGINIA
PENNSYLVANIA
NEW YORK
MAINE
VT.
N.H.
MASS.
CONN.
R.I.
N.J.
DEL.
MD.
DIST. OF COL.
LEGEND
Over 1,500 Addicts
500 to 1,500 Addicts
200 to 500 Addicts
0 to 200 Addicts

The public and Congress became aroused and the Harrison Act resulted in 1914. During World War I, a vast number of Americans, including both the military and civilians, were drug addicts. (Statistics on the subject at that time were not carefully compiled but there were indications that there were at least 200,000 addicts—probably many more.) Today's estimated total is 60,000 of whom about 46,000 have been officially reported. Therefore, the new Federal law and its enforcement have proved to be highly desirable, especially after being rounded out by subsequent laws and by policing and hospitalization activities.

But things got off to a halting start. The Harrison Act had to await the end of the first world war in 1918 before implementation could begin. The war had cut down sharply on the supply of narcotics and the demand had increased for medical purposes for the military. Large numbers of addicts clamored for relief.

Various States and cities hastily set up clinics to provide narcotics for addicts in the mistaken belief that this would keep addiction under control. However, within a few years all these clinics were abandoned.

The Federal Bureau of Narcotics

In 1930, the Federal Bureau of Narcotics was created in the U.S. Treasury Department at Washington. The Bureau's job includes the implementing of laws governing narcotics. It regulates and controls trade in these drugs in the United States and cooperates with the representatives of foreign countries assigned to do similar jobs abroad.

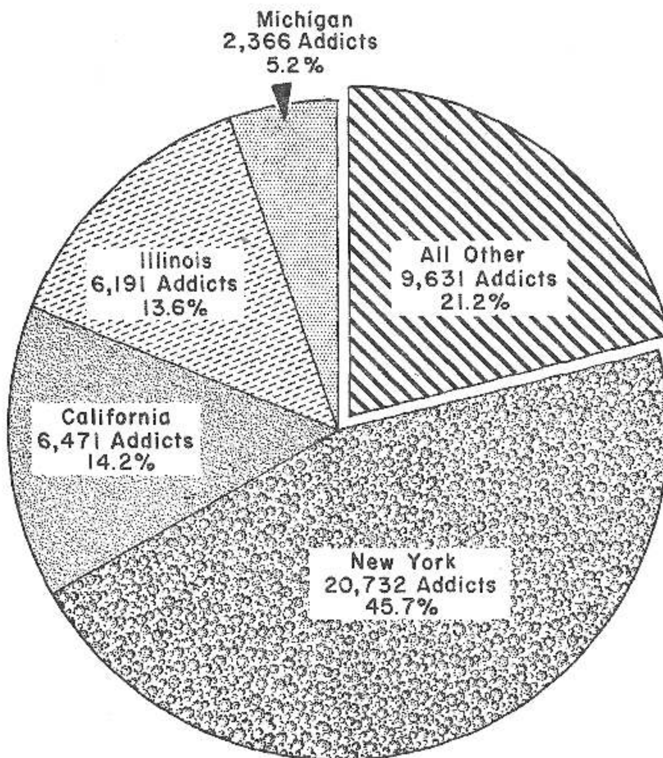
The Bureau supervises American imports and production of narcotics. It apprehends violators of narcotic laws. It cooperates with the Bureau of Customs which does a yeomen's job of curbing smugglers. In several foreign countries both Bureaus have agents who collaborate in trying to prevent illegal shipments to the United States.

Medical and Legal Professions

The work of the medical profession in connection with narcotics deserves praise. Physicians prescribe such drugs with skill and care. They do whatever they can to prevent addiction. In fact, little serious addiction in the sense of anything needing to be done about it results from medical use of drugs.

The medical, dental, and veterinary professions have sole responsibility for use of drugs to relieve suffering. They alone are competent to prescribe narcotics. They are limited by law from prescribing primarily to maintain addiction.

Members of the legal profession have a closeup picture of addiction which they know rates extremely high as a cause of crime and racketeering. Lawyers universally want to help prevent narcotic addiction. They cooperate wholeheartedly with Federal, State, and municipal authorities in trying to abolish illegal traffic in drugs.



Lawyers form the largest single group in the United States Congress and both Senate and House subcommittees studying addiction had much assistance from the legal and medical professions and other organizations and persons.

There is a constant need for great cooperation between the medical and legal professions for doing all in their power to wipe out the international disgrace of drug addiction.

International Relations

The United States, along with more than 80 other nations, has agreed to work vigorously for proper and effective control of narcotic drugs. Our Government has had many tributes at home and abroad for showing leadership in the handling of narcotics.

Since smuggling is the principal source of supply for addicts, teamwork among the various countries is essential. International cooperation has done much to control production of raw materials and to confine their conversion to medical and scientific purposes. The United Nations Commission on Narcotic Drugs and the World Health Organization, as well as individual countries, have served well in this direction.

To indicate the extent of international efforts to control narcotics, mention is made of several organizations working on the problems involved:

1. The U.N. Commission on Narcotic Drugs, the supervisory and policymaking body, continuously surveys activity in all countries, studies and recommends improved control measures, and makes appeals for public support.
2. The Permanent Central Opium Board and the Drug Superivsory Body collaborate on statistics and estimates of the various governments and keep track of international trade.
3. The Expert Committee on Drugs Liable to Produce Addiction (part of the World Health Organization) concerns itself with medical phases of addiction.
4. One part of the U.N. Secretariat—the Division of Narcotic Drugs—seeks to implement treaties, plan more effective measures, and handle scientific research.

Activities of the U.S. Congress

Both the Senate and House of Representatives of the United States Congress have shown great interest in the problems of narcotic addiction for the past two generations.

They have studied the subject intensively and have supported needed legislation. In recent years the Committee on the Judiciary, U.S. Senate, reported on preliminary findings and recommendations of its subcommittee after unusually exhaustive hearings. Likewise, the House Committee on Ways and Means has made thorough studies and has reported through its Subcommittee on Narcotics.

Congress has passed several main laws under which narcotics are controlled:

a. Harrison Narcotic Act

As reenacted in the Internal Revenue Code, the Harrison Narcotic Act calls for taxes on everyone who imports, produces, sells, or dispenses narcotics.

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The effect of this Act, of course, is to police the production and sale of these drugs and make sure they go through professional channels and are used only for medical and scientific purposes.

b. Marihuana Tax Act

According to a quotation from a U.S. Supreme Court decision, "In enacting the Marihuana Tax Act, the Congress had two objectives: First, the development of a plan of taxation which will raise revenue and at the same time render extremely difficult the acquisition of marihuana by persons who desire it for illicit uses and, second, the development of an adequate means of publicizing dealings in marihuana in order to tax and control the traffic effectively."

Under the law a physician can write a prescription for marihuana and a pharmacist can fill it. But the use of this drug for medical purposes is considered nil. It has no therapeutic value whatsoever. Therefore, both in the United States and countries abroad, marihuana has been dropped from most of the listings in pharmacopoeias.

c. Narcotic Drug Import and Export Act

Under the Import and Export Act, the Commissioner of Narcotics studies and prescribes how much opium and coca leaf are needed for manufacture of drugs for medicine and science in the United States.

As for our exports of narcotics, we try to safeguard other countries' interests by tight control. We make sure that narcotics sent abroad are strictly for medical or scientific purposes.

d. Controls of Synthetic Narcotics

Isonipecaine (Demerol) was the first totally synthetic narcotic drug made from commonly available materials. Addicts found that it could be substituted for morphine or heroin. Also it was found that primary addiction resulted from prolonged use of this wholly synthetic product.

Therefore, in 1944, Congress passed a law putting the drug under the same controls as for narcotics derived from opium and cocaine. Two years later Congress passed another law, commonly referred to as the Robertson amendment, to tighten up further on synthetic narcotics. It defines the word "opiate" to include any drug that is found to have addiction forming or addiction sustaining liability similar to morphine or cocaine. This is the general law under which a considerable number of synthetic drugs have been brought under narcotic control in the United States.

e. Narcotic Control Act of 1956

To strengthen Federal efforts to control violations in narcotic drug traffic, the Narcotic Control Act of 1956 was enacted. Imprisonment of 2 to 10 years and a possible maximum fine of $20,000 were provided for a first

offense involving unauthorized possession of narcotics—also a minimum mandatory sentence of 5 years in prison for first offenses of illegally selling narcotics or marihuana. Subsequent offenses call for 10 to 40 years and fines up to $20,000. No probation, parole, or suspended sentence is allowed except in the case of a first offense involving unauthorized possession of narcotics. The heaviest penalty of all allows 10 years to life imprisonment, or even death, at the discretion of the jury, for sale or transfer of heroin by a person more than 18 years old to another person who is under the age of 18.

The new Narcotic Control Act gives greater authority to the Bureau of Narcotics and the Customs Bureau. This applies to making searches, seizures, and arrests in the investigation and prosecution of violators of Federal narcotic laws. When probable cause exists, search warrants may be allowed around the clock—any time of day or night.

Provision was made for more extensive compilation and dissemination of information and statistics for purposes of law enforcement. Another forward step, under the new law, is authorization of training program for narcotic enforcement officers at the state and local levels.

Which Controls Work Best?

Discussion has arisen about setting up new clinics for legal and continuing dispensing of narcotics to addicts, as one way to help to control and treat addiction.

This idea has met with opposition which is well informed and experienced. There is, of course, general agreement on at least two points:

Everyone wants to help find the best possible solutions to narcotic addictions—both prevention and treatment; any additional accurate information and needed research are welcome.

In this booklet three major questions are discussed:

I. Are Clinics Dispensing Narcotics to Addicts Practicable and Desirable?

This includes the idea of so-called "ambulatory treatment" whereby a patient goes into a clinic, gets "serviced" whenever required and then goes on his way. This is in sharp distinction to being treated for a period in a specialized institution out of contact with drugs.

Under the law in the United States, the physician has the responsibility for prescribing and dispensing properly any narcotic drug. Without regard to the matter of addiction, which is not rated as an incurable disease, a physician following the precepts of his profession may prescribe and dispense narcotic drugs to relieve severe pain or other serious conditions.

But the proposed clinic plan would change this current basic concept of handling addicts. It would involve dispensing of narcotics to addicts who apply to a clinic to get as much of the drugs as they need to maintain their ordinary level of usage.

The trade of dope peddling is looked upon by the public generally as one of the most detestable of all. For Government-sponsored clinics to distribute narcotics to addicts would certainly run counter to public opinion and moral standards. Such clinics would undoubtedly lend an air of respectability to continued narcotic addiction.

Experience in America in the early 1920's and in certain other countries shows that such clinics cause the number of addicts to increase rapidly. This weakens the health and morals of a nation.

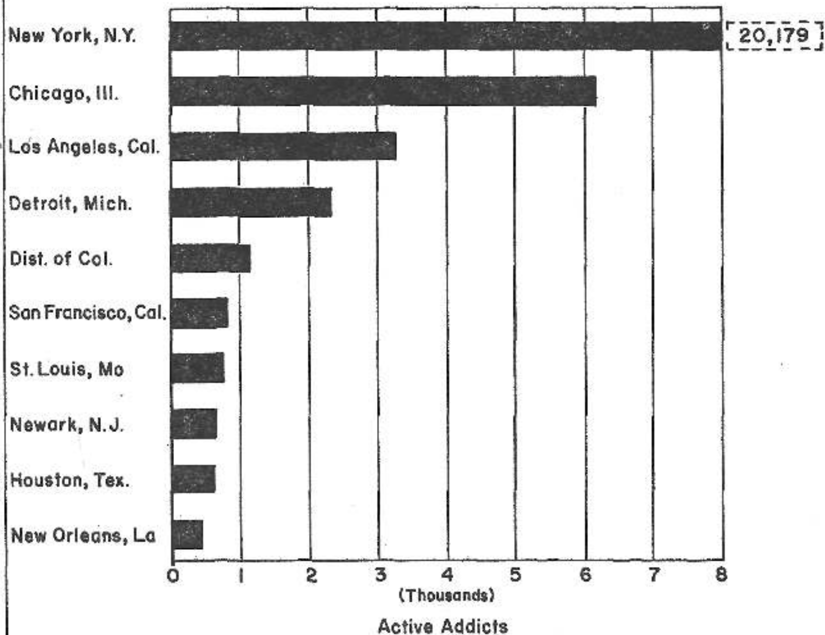
In fact, widespread drug addiction has been used as a powerful military weapon. Before Japan invaded China in the 1930's it flooded the intended victims with free or low-cost narcotic drugs with the intention of reducing the willingness or capacity for resistance. Today Red China is guilty of similar strategy by pouring narcotics into countries the Red Chinese hope to weaken.

Federal Bureau of Narcotics

TEN LEADING CITIES IN ACTIVE NARCOTIC ADDICTS REPORTED IN THE UNITED STATES

AS OF DECEMBER 31, 1959

(As of December 31, 1959, there were 45,391 Active Narcotic Addicts reported to the Federal Bureau of Narcotics. The 10 cities listed below comprise 80% of this figure.)



One principal reason for dismissing the idea of free drug clinics is that they would clash head-on with our country's solemn agreements with most of the world's nations. The United States has been making agreements on control of narcotics with other nations for nearly 50 years with growing scope and success.

To condone "free drug areas" instead of striving for "drug free areas" would violate the spirit and the purpose of our international agreements. To compromise or relax these controls would cause us to lose prestige and respect we have gained in the family of nations.

Another main objection to the proposed clinics is that they contradict the Nation's internal policies and practices which have been developed in the

last 25 or more years. This solid buildup includes the body of acts of the U.S. Congress and various State laws and rulings of the Supreme Court.

Abuses would inevitably result from widespread distribution of narcotics as was the case in the earlier experiments. This was true despite competent and ethical supervision of the distribution. There was simply too much of a supply available at little or no cost. Those who were already addicts had no incentive for rehabilitation. Furthermore, they tried successfully in many cases to create new addicts among persons close to them, for instance, members of their families and other intimate associates.

The proposed clinics would undo the successful work in handling addiction during the past two generations.

Supreme Court Ruling:

The United States Supreme Court in 1919 made a basic ruling affecting this situation. It was asked in effect, this question:

> If a physician issues an order for morphine to an habitual user thereof, not in the attempted cure of the habit, but for providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such order considered to be a physician's prescription qualified under an exception of a section of the Harrison Narcotic Law?

In its reply, the Court stated that:

> To call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required. That question should be answered in the negative.

American Medical Association:

From the professional standpoint, the American Medical Association made another important statement through a special committee of physicians in 1924, as follows:

> Your committee desires to place on record its firm conviction that any method of treatment for narcotic drug addiction, whether private, institutional, official or governmental, which permits the addicted person to dose himself with the habit-forming narcotic drugs placed in his hands for self-administration, is an unsatisfactory treatment of addiction, begets deception, extends the abuse of habit-forming narcotic drugs, and causes an increase in crime. Therefore, your committee recommends that the American Medical Association urge both Federal and State governments to exert their full powers and authority to put an end to all manner of such so-called ambulatory methods of treatment of narcotic drug addiction whether practiced by a private physician or by the so-called "narcotic clinic" or dispensary.
>
> In the opinion of your committee, the only proper and scientific method of treating narcotic drug addiction is under such conditions of control of both the addict and the drug, that any administration of a habit-forming narcotic drug must be by, or under the direct personal authority of the physician, with no chance of any distribution of the drug of addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment (p. 187–188).

The A.M.A. study and decision followed a series of disillusionments for sponsors of the drug clinics.

BUREAU OF
TREASURY I

OFFICE OF THE

1. Enforces and administers ge[...] narcotic and marihuana law[...]
2. Cooperates with State Depa[...] obligations under internation[...] treaties;
3. Cooperates with Customs, In[...] services and other Federal [...] to control of the use and s[...] narcotics; and
4. Cooperates with the several [...] abuse of narcotics and mari[...] jurisdictions.

FIELD OFFICE SUPERVISOR

Inspects field offices, making complete internal audits of operations; installs uniform procedures and organization; and reports on the effectiveness of operations and general conditions of narcotic law enforcement within the several districts.

OFFICE OF THE D

1. The Deputy acts as Commissi[...] Commissioner;
2. Exercises general supervision [...] the field force, with particu[...] administrative functions; and
3. Assists the Commissioner gene[...] narcotic and marihuana law e[...]

ADMINISTRATIVE DIVISION

1. Handles all details of matters of general administration, including:
   (a) Budget and Fiscal
   (b) Personnel
   (c) Supplies and Equipment
   (d) Messengers

LEGAL DIVISION

1. Interprets statutes, regulations and decisions;
2. Reviews narcotics and marihuana cases and the action thereon;
3. Recommeds actions on pardons and paroles; and
4. Assists in legal review of proposed international conventions and protocols and national legislation.

ENFORCEME[...]

1. Directs investigations [...] narcotics and marih[...]
2. Gives general superv[...] and
3. Maintains criminal [...]
4. Directs activities of [...] Training School.

14 DISTRI[...]

1. Conduct investigations of [...] marihuana laws;
2. Examine narcotic orders of [...] practitioners for excessive [...]
3. Maintain liaison with U.S. C[...] officials at local levels.

NARCOTICS
)EPARTMENT

COMMISSIONER

ıerally the several Federal
s;
rtment in discharge of
al narcotics conventions and

ernal Revenue, Armed
agencies in matters relating
ppression of the abuse of

states in suppressing the
huana in their respective

EPUTY COMMISSIONER

oner in the absence of the

over the Bureau, including
lar emphasis on

rally in all matters of
nforcement and administration.

DRUGS DISPOSAL COMMITTEE

Examines and disposes of drugs seized or purchased as evidence, surrendered as excess stocks by registrants, or otherwise coming into custody of the Bureau of Narcotics.

NT DIVISION

; of violations of
uana laws;

ision to field force;

dentification files.

Bureau of Narcotics

RETURNS DIVISION

1. Directs matters pertaining to imports, exports, storage, manufacture and distribution of narcotics thru legitimate channels for medical and scientific purposes;
2. Accounts for drugs coming into custody of narcotics and customs officers as evidence or by surrender;
3. Compiles miscellaneous statistics for administrative and reporting purposes.

STATISTICS AND RECORDS DIVISION

1. Receives, correlates, distributes and dispatches all bureau mail and other communications, including criminal investigation reports, related documents and classified material;
2. Compiles and prepares for study, research or dissemination, statistical reports concerning addiction, narcotic and marihuana traffic.

T OFFICES

iolations of narcotics and

pharmacists and
purchases;

ourts, state, and municipal

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE, BUREAU OF MEDICAL SERVICES

June 14, 1960.

Mrs. ZAIO SCHROEDER,
General Federation of Women's Clubs,
Park Sheraton Hotel,
Washington, D.C.

DEAR MRS. SCHROEDER: In response to the inquiry made by Mrs. Baldwin the following information is provided.

Experiences of physicians of the Public Health Service, Department of Health, Education, and Welfare, with thousands of narcotic drug addicts over a period of many years support the principles adopted by the American Medical Association in 1924,[1] that narcotic drug addicts should be treated in hospitals where the patient and the drugs are under the direct personal control of the patient's physician.

Experience also has shown that most narcotic drug addicts are unable to cooperate in treatment and that a procedure for civil commitment like that used for patients with other types of mental diseases is a most useful method for the authority and responsibility to be placed in the hands of the physician in order that he may exercise his medical judgment in the care of the patient.

Physicians of the Public Health Service, Department of Health, Education, and Welfare, are on public record stating that distribution of narcotic drugs to addicts could not be recommended. Such distribution serves to perpetuate the disease and has many unsolved and potentially dangerous aspects and that the objective should be to treat and rehabilitate the addict so that he will become a healthy and productive person.

Sincerely yours,

JAMES V. LOWRY, M.D.,
Assistant Surgeon General
Chief, Bureau of Medical Services.

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[1] Report to the Council on Pharmacy and Chemistry, The Journal of the American Medical Association, Vol. 149, pp. 1220–1223, July 26, 1952.

RESOLUTION ADOPTED BY THE GENERAL FEDERATION OF WOMEN'S CLUBS AT INTERNATIONAL CONVENTION AND 69TH ANNUAL MEETING, WASHINGTON, D.C., JUNE 15, 1960

Care and Rehabilitation of Drug Addicts

WHEREAS, The declaration of the Congress of the United States, the United Nations Commission on Narcotic Drugs, and the National Research Council, is that narcotic drugs should not be used to gratify addiction; and that in the treatment of drug addiction methods of ambulatory treatment and open clinics are not advisable; and

WHEREAS, It is realized that the sale and use of narcotic drugs should be strictly limited to medical needs and that experts in treatment of narcotic addiction have repeatedly emphasized that most addicts cannot be treated effectively and rehabilitated unless required to submit to legal restraint in closed institutions; and

WHEREAS, The General Federation of Women's Clubs is in opposition to proposals which advocate experimentation with established facilities for legalized distribution of narcotic drugs to addicts for maintenance of their addiction; and

WHEREAS, It is noted that signal progress has been made in the United States, particularly in those states where there is rigid enforcement of severe and mandatory laws, which has resulted in a marked reduction of drug addiction and in deterrence of unlawful sale of narcotics; therefore

RESOLVED, That the General Federation of Women's Clubs strongly urges compulsory hospitalization for addicts where facilities are available in the effort to cure, to rehabilitate, and to prevent further addiction; and further

RESOLVED, That the General Federation of Women's Clubs urges the Congress of the United States to maintain the provisions of the National Narcotics Restriction Act of 1956.

Failure of U.S. Clinics in the 1920's:

According to a book "The Traffic in Narcotics," by Harry J. Anslinger, U.S. Commissioner of Narcotics, and William F. Tompkins, formerly U.S. Assistant Attorney General, the authors sum up their views on the clinic idea as follows:

> The United States has spared neither time nor money in getting at the basic truth in regard to drug addiction and every effort has been made to help the addict, but it is known that the narcotic clinic has been of no avail. The clinic idea, which simply supplies the addict with his drug for an indefinite period, creates a vicious circle. In this connection, it is interesting to note that most of the advocates of this system do not even go so far as to advocate a "cure.' It is simply set forth as a plan whereby the addict maintains his old habit and invariably returns to the clinic where a fresh supply is administered or given to him for a small sum, and the victim again set at large to contaminate others to his ranks; this procedure to be continued indefinitely.
>
> This method of treatment has never yet proved successful anywhere in the world, and it has been given sufficient trials that would have shown the merits if any had existed. Certainly anyone with even cursory knowledge of the situation realizes the complete futility of the narcotic clinic. The American Government would never tolerate such a system based on the degradation of its citizens.

Beginning in 1919 the numerous clinics established in America turned out to be a bonanza to drug addicts who were assured of a free or cheap source of ample supply. Many "patients" received heavier than customary dosages of drugs.

Also many so-called patients had records of criminality. They moved from one city to another to find the most free-and-easy outlets. They supplemented their living costs by thefts and other undesirable activity. Overworked physicians in charge of clinics dealt with large numbers of addicts who often were unknown locally and who made plausible appeals of various kinds. There has been no criticism against the physicians in charge—only against the basic idea of the clinics and the disastrous results.

Therefore, by the middle 1920's, all the clinics were discontinued with full consent of State and municipal authorities as well as that of the medical profession.

About 50 narcotic clinics had been set up in 40 cities mostly in the metropolitan areas, either under State or municipal control. The theory behind this action was that these clinics, with drugs sold for little or nothing, might provide an easy answer to handling important addiction problems.

There is no question that most of the sponsors of the clinic concept were dominated by worthy motives. For one thing, they thought it would reduce the large amount of crime resulting directly from addicts who resorted to stealing or other offenses in order to get the money to pay for the high cost of drugs. And somehow the sponsors seemed to think that a spread of addiction would not result.

But as early as 1921 a report was made by a member of the American Medical Association's Committee on Narcotic Drugs, who took a dim view of the clinic situation. So much of what he reported would apply today, that we quote key portions of his report:

> 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 apple in a barrel of sound ones.
>
> Public opinion regarding the vice of drug addiction has been . . . corrupted through propaganda. . . . Appeals to that universal human instinct whereby the emotions are stirred by abhorrence of human suffering in any form, or by whatever may appear like persecution of helpless human beings . . . are brought to bear on an unsuspecting public to encourage it to feel pity for the miserable wretches, "whose name is legion" we are told, and whose "sufferings" . . . are graphically served up to be looked on as if they were actually being made "victims of persecution" by the authorities, who would deprive the wretches of even the drug they crave.
>
> Significant articles of sensational character dealing with narcotic addiction have appeared in the public press denouncing the alleged "persecution" of the addict and . . . well calculated to create in their favor popular prejudice.

The largest of the experiments, and perhaps the best documented, occurred in New York City. The Department of Health in that city analyzed the cases of about 8,000 addicts handled by the local clinics. Well qualified analysts reported that, after a thorough study, "we honestly believe it is unwise to maintain it (the clinic system) any longer."

In New York and some other cities serious attempts were made to cure and rehabilitate addicts in hospitals cooperating with the clinics. But ambulatory treatment was the one most widely used and it failed utterly. Many addicts weren't willing to spend the time to travel to and from the clinics, day and night. They wanted to carry away a stock of drugs for self-administration.

Many statistics are available from prison records. In Sing Sing the number of drug addicts who were admitted jumped 900 percent between 1920 and 1923. Similar increases in number of addicts occurred in other large prisons, obviously attributable to the operation of the clinics.

In 1922 in the Atlanta Penitentiary 20 percent of the prisoners were drug addicts and this was not uncommon among other Federal penal institutions. Then the clinics closed and by 1952, only 7.8 percent of the Federal institution prisoners in Atlanta were addicts.

During the era of the clinic experiments, narcotic peddling boomed. But by 1952 the illegal drugs which were being seized had dropped to one fourteenth of the earlier figure. The amount of illicit narcotics seized in the entire United States in 1952 was no more than what was captured annually in New York State alone in the early 1920's when the clinics were operating there.

Other large population centers, such as Los Angeles, Providence and Atlanta, reported shocking results from the operation of narcotics clinics. Even smaller cities had their share of trouble—such as Shreveport and Alexandria, La.

Canadian Opinion on Clinics:

Canada and the United States parallel each other closely in most phases of the addiction situation. There is about the same amount of addiction

per capita, concentrated mostly in large cities. Laws and policing methods in the two countries resemble each other. The Canadian Government, its enforcement personnel, and leading medical authorities oppose the idea of the proposed clinics for addicts.

A composite of many statements by Canadian authorities might read about as follows:

Giving addicts narcotic injections at cost price does not solve the problem. This merely condones drug addiction officially and gives a stamp of public approval on a vicious and soul-destroying habit and comes close to the addict's dream of a barrel of heroin on every street corner.

Abstinence is the only salvation. An addict receiving a daily shot at a Government clinic would not be satisfied and would try to get additional supplies from illicit sources. This means that the addict would continue as an addict and commit crimes to get the money to buy additional narcotics.

Most of the drug addicts in Canada are the criminal addicts whose addiction in its inception and in its continuance is due to vice, vicious environment, and criminal associations.

Among prisoners in Canada the best results in effecting improvement are obtained among those who are compulsorily committed for treatment and later released on parole. A thoroughgoing followup service is vital and this requires compulsion.

Heavy penalties for addicts who break their parole are widely favored in Canada.

The Parliament, Government, and many leaders in the medical profession in Canada have expressed themselves along similar lines.

The "British System":

The reason for discussing the "British System" of narcotics control is primarily because it has been misused for propaganda purposes by proponents of the proposed clinics for addicts in North America.

As a matter of fact, the British apply narcotic law controls pretty much the same as it is done in the United States and Canada. All three countries support the same international agreements and conventions.

The following statement in 1956 by the United Kingdom Home Office's publication to doctors and dentists seems to be in accord with the thinking in the United States and Canada:

> In no circumstances may dangerous drugs be used for any purpose other than that of ministering to the strictly medical or dental needs of his patients. The continued supply of dangerous drugs to a patient solely for the gratification of addiction is not regarded as "medical need."

One variation in policy is given in the following quotation by British authorities about an exception in a certain case:

> . . . where it has been demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued. (But whether there really are such people is debatable.)

An important difference between England (not counting the remainder of the British Empire) and the United States and Canada is that in large cities in North America the crime rate is higher.

The English are notably law abiding, but when British subjects, for instance in Hong Kong and Singapore, are included, the picture of drug addiction changes tremendously. Hong Kong alone, according to a Government White Paper issued in November 1959, has between 150,000 and 250,000 addicts, which indicates a rate of addiction several times that of the United States. And yet these overseas British citizens are subject to the same narcotic law enforcement as their cousins in London. So there is no legerdemain in the "British System." Much depends on the widely varied conditions.

Another example of "comparing apples with oranges" is found in the reporting of addiction in England and that of the United States and Canada, which is more extensive. In England only a few hundred persons are on record as being narcotic addicts. But the trial of a former British doctor indicated that he had created more addicts among his patients than the total number of persons reported to be addicts in the entire country.

In the United States and Canada, however, it is believed that within one to two years most addicts are identified as such. Reports come from doctors, teachers, police, Federal agents, members of the addict's family or solicitous friends.

There is believed to be more violation of hashish and opium smoking in the United Kingdom (prevalent among the nonwhite population) than in the United States and Canada. (The British do not list the opium users, whereas the Americans do.) One principal thing to remember is that cultures and people differ widely from one country to another.

Addiction in Denmark:

Denmark is mentioned because its experience has a real bearing on legalized clinics. For a period of years it allowed a liberal amount of various narcotic drugs to be released for addicts and others. Denmark is now the world's largest consumer per capita of various narcotic drugs. These do not parallel some of those most commonly used by addicts in the United States but the results of legalized clinics do apply.

According to U.N.'s Permanent Central Opium Board, when added together, the per capita consumption for six narcotic drugs in Denmark not only single out that country as the biggest consumer but exceed by 60 percent the corresponding total for the country occupying second place. Leaving aside the figures for codeine and ethylmorphine which are regarded as less liable to produce addiction than other narcotic drugs, Denmark's consumption is still 11 percent higher than that of the next highest consumer.

Based on the record of U.N.'s Commission on Narcotic Drugs there was a 40 percent increase in narcotic prescriptions in Denmark between 1949 and 1955, only partly accounted for by a gain in population.

Denmark has been tightening its controls in the last few years. But its experience with loose reins on narcotics has been significant.

Other Countries:

During the time Formosa was under Japanese occupation opium smoking was legal and was furnished by the Japanese government at approximate cost to the addict of 8 cents a day. During 7 years 57,073 crimes committed by the natives were classified. Close to 71 percent of criminality was among opium users, with less than 30 percent among nonusers.

There seems to be no question that this high rate of criminality among opium addicts exists in spite of low cost and ready availability of the drug.

The age-old practice of eating opium in India ended early in 1959. In Iran opium smoking has been banned and the Iranian Government decided against rationing any supplies to addicts. Immediately after gaining their independence Tunisia and Morocco closed their government hashish shops.

Opium smoking has been banned in Thailand as of June 30, 1959.

II. Is Compulsory Hospitalization, Under Skilled Care and With Adequate Facilities, Essential for Rehabilitation of an Addict?

This question brings up the point as to whether such hospitalization is needed to help prevent "contagion" by addicts among their non-addicted associates.

An apt statement about controlling the addict has been made in *American Journal of Psychology* (by Dr. J. D. Reichard, Vol. 103, No. 6, May 1947):

> Control of the addict for a period of one year is imperative. Sometimes the period of control must be longer; for a few, such control must be life long.

An addict doesn't necessarily have to be confined to an institution for a long period in order to effect a cure. But he does need to have expert care in a hospital for at least several months. When released the patient should be under close supervision of a properly trained person who is close at hand in order to be available continuously and who can send the patient back to an institution for additional treatment which is indicated.

States and cities should develop legal means for an addict to be obliged to get the treatment he needs whether he wants it or not. This already has been worked out to cover mental health cases. A drug addict lacks self control, so he should have the right care in a place where he cannot have access to drugs.

In this situation, help is required from the legal profession, State legislators, and others in order to devise and carry out controls at the State and city levels. These are essential in order to make certain that the addict gets treatment in a hospital or other suitable institution and sensible controls after his discharge.

When drugs are abruptly and completely withdrawn from a patient, he usually goes through a short period of intense suffering (fatalities have

sometimes resulted). It is generally considered humane to withdraw the drugs rapidly and to substitute another drug. This substitute drug is reduced in dosage over a period of 1 to 2 weeks.

A large part of the widely approved treatment consists of a period of rehabilitation and psychotherapy. Considerable time under close supervision is essential for rehabilitation in an institution. Recreation is provided. But more important each patient is assigned to useful jobs in which he takes advantage of his aptitudes or work skills. Many addicts have special talents which can be applied in productive work.

Following treatment in an institution, the big problem is to head off chances of a relapse. Everyone concerned with this field could help by urging the training of more people for the task of guiding the addict through the months and years after he leaves an institution.

"Everyone," of course, includes lawyers, doctors, educators, ministers, editors, lecturers, opinion leaders of many kinds, elected and appointed public servants, and the general public itself.

A good deal of public education on how to handle an addict who is in the process of rehabilitation would also help a great deal. Too many agencies and individuals fail to show sufficient interest in anything having to do with drug addiction, although collectively they interest themselves in nearly every other kind of human problem.

Federal Treatment Facilities:

The largest facilities for treatment of narcotic addicts were opened by the Federal Government in 1935 in Lexington, Ky., with an added hospital in Fort Worth, Tex. There are other facilities set up by State or local governments, such as those at New York City and Chicago. But by and large, States and cities have made too few serious attempts to treat and cure drug addiction, although they are keenly concerned with other major mental and physical diseases.

The Lexington and Fort Worth institutions together have 2,200 beds. Patients are allowed to stay long enough to get thorough and skillful handling. Both research and treatment are combined in the program at Lexington.

The hospital at Lexington represents a large undertaking. Located in an attractive setting of farm land, it provides activity for patients in farming and maintenance work and in furniture and garment plants. More than 500 medical and hospital personnel provide the staff to care for 3,000 patients per year including both men and women.

Principal forms of athletic recreation include baseball, tennis, and bowling. In addition to entertainment through movies and music, there are educational courses and libraries. Religious services—Protestant, Catholic, and Jewish—are held by chaplains in the hospital's chapel.

In the opinion of the United States Public Health Service, the National Institute of Mental Health and other topflight groups, as well as the Bureau

of Narcotics, many patients at these Federal hospitals have been benefited. The research which has been and is being done at Lexington promises further progress for the future.

III. Is Strong Enforcement of Present Federal, State, and Local Narcotic Laws, with Heavy Penalties, Necessary and Effective?

"The most effective means of combatting the narcotic problem is through enforcement facilities." That is a quotation from a report of the U.S. Senate Committee on Organized Crime in Interstate Commerce. Similar statements and findings have come from many other sources. Here is some of the background:

Narcotic addiction in the United States took a sharp drop between the late 1920's and World War II. At the close of that war, addiction had reached an unusually low point. There had been a fairly sizable field force of the Bureau of Narcotics. Penal narcotic laws had been enforced.

After World War II, addiction began to rise, especially among young people. Part of this no doubt resulted from the spread of juvenile delinquency. But another reason was a reduction of 25 percent in the Bureau's field force when vast sums were needed to step up our national military program. However, by 1952 Congress provided for urgently needed personnel for the Bureau.

Somewhat similar reductions had occurred in State and city budgets for officers to police narcotics activities. Or enforcement specialists were assigned part or full time to other duties. Addiction being so low in 1946, many local agencies were caught off guard during the upsurge of addiction soon afterward.

One factor in the early postwar gain in addiction was the situation in the courts. Previously most of the courts had taken a firm attitude in dealing with the narcotics field. Stiff sentences had made the racketeers for the most part steer clear of traffic in drugs.

But when addiction reached its low point around 1946, an attitude of leniency came into being and short sentences were quite prevalent. This unintentionally meant a green light to the "purveyors of living death."

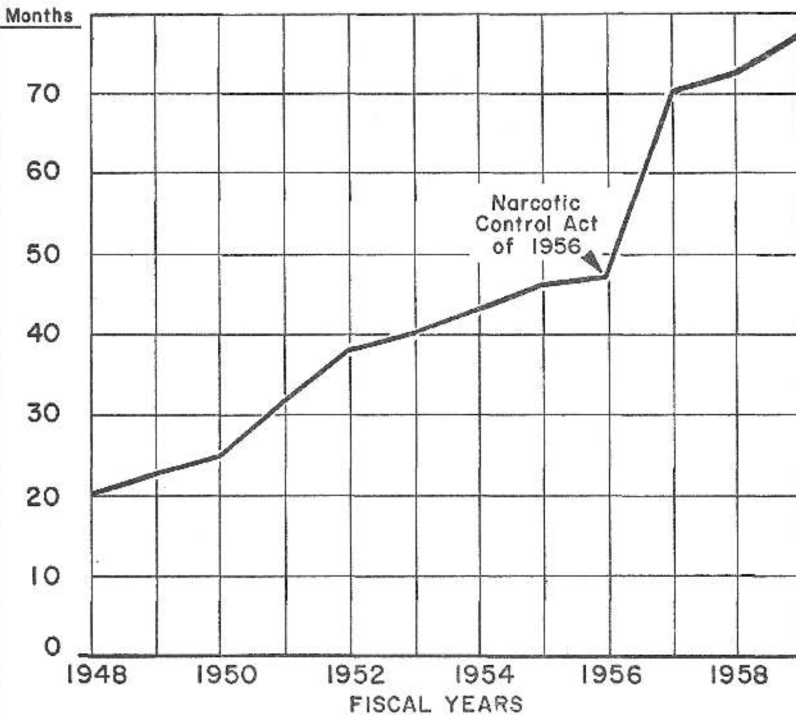
At the same time there were unusual delays in prosecution of cases brought to justice in many cities. Frequently the Bureau and local officers would have to arrest a violator several times before he was tried for the first time.

On top of all this, a postwar series of Supreme Court decisions slowed up enforcement procedures. But there now seems to be a stiffer attitude, based on a recent decision.

One answer to carrying out the law with meaningful sentences and penalties is given in the Boggs-Daniel Narcotic Control Act which was passed by the U.S. Congress in 1956, mentioned earlier in this booklet. It provides penalties of 5 to 20 years for a first offense and 10 to 40 years for a second or subsequent offense of unlawful sale or possession of narcotic drugs. Very

86 U.S. District Courts

AVERAGE LENGTH OF NARCOTIC SENTENCES IN 86 U.S. DISTRICT COURTS FISCAL YEARS 1948—1959



Data obtained from the Annual Report of The Director of the Administrative Office, U.S. Courts.

few offenders will take a chance on such severe odds. When they got a light sentence of 6 months or a year, they had called it a "vacation." They had made piles of money and didn't mind coasting for a while. Now it is different, in localities where the law is enforced.

Every State has a narcotics law of some kind. But all of these laws should be made as strong as the Boggs-Daniel law. Several States have already taken such a step.

The responsibility of the Federal policing of narcotics is the heaviest because of the multiple state enforcement. Also the Federal authorities

handle the international problems in cooperation with authorities of other countries.

But strong State and municipal backing is vital. In fact, such local and Federal cooperation is one of the brightest spots in the whole picture. This State and local cooperation needs to be nationwide, however, because when there is a crack-down on violators in certain States and cities the racketeers move elsewhere. One thing especially desirable is to have more States and cities create the essential facilities and personnel to cope with the problem.

The criminal addicts include shoplifters, pickpockets, persons who make a living by crooked gambling and confidence schemes, and many others. They usually find it necessary to move rather rapidly from one town to another before they are known to the police. They operate chiefly in crowded centers where they find more victims and can more easily escape detection.

Local officers can be of tremendous help when they arrest a dope peddler by trying to run down the sources of his supply. This may uncover an extensive network of illegal activity.

The local and Federal guardians of the public welfare in dealing with addicts who are criminals often have to take long chances in enforcing the law. Many enforcement people have been killed or badly wounded by addicts.

Report of President's Committee:

A report was made in 1956 by an Interdepartmental Committee on Narcotics to the President of the United States. In part, it had the following to say about the necessity of severe penalties for violations of the narcotic laws:

> The Committee has arrived at the conclusion that there is a need for a continuation of the policy of punishment of a severe character as a deterrent to narcotic law violations. It therefore recommends an increase of maximum sentences for first as well as subsequent offenses. With respect to the mandatory minimum features of such penalties, and prohibition of suspended sentences or probation, the Committee fully recognizes objections in principle. It feels, however, that, in order to define the gravity of this class of crime and the assured penalty to follow, these features of the law must be regarded as essential elements of the desired deterrents.

Committee Report:

Also in 1956 subcommittees in both the U.S. Senate and House reported on illicit traffic. They opposed clinics and favored compulsory hospitalization and heavy penalties. Here is the portion of the House report devoted to the subject of penalties:

> Effective control of the vicious narcotic traffic requires not only vigorous enforcement but also certainty of punishment. Conclusive evidence was presented during your subcommittee's investigation that the imposition of heavier penalties was the strongest deterrent to narcotic addiction and narcotic traffic. In those areas of the country where we found leniency in sentencing the prevailing practice, drug addiction and narcotic traffic without exception are on the increase. Also without exception wherever heavier penalties are imposed by the courts narcotic traffic and addiction are at a virtual minimum or nonexistent.

Unless immediate action is taken to prohibit probation or suspension of sentence, it is the subcommittee's considered opinion that the first-offender peddler problem will become progressively worse and eventually lead to the large-scale recruiting of our youth by the upper echelon of traffickers. The penalties on peddlers with or without a record of prior convictions under our narcotics law must be made sufficiently severe to make the profits from his insidious commerce an inadequate inducement to assume the risks involved.

Examples of Value of Heavy Penalties:

Experience has shown that lenient handling of the criminal engaged in narcotic activity does more harm than good. Naturally the punishment should keep step with the enormity of the crime.

One of the most clearcut case examples of the value of dealing sternly with narcotic law violators is found in what happened in Ohio. Some tributes to this project may have been somewhat overdone. But all that is needed is to state the facts.

Ohio's narcotic laws several years ago had weaknesses and loopholes. As a result violations were greater than in nearby States. But in 1953 a strong campaign started in Ohio to cut down drastically on its illicit traffic in narcotics. The General Assembly gave its blessing to a thorough study of the situation. Advisory committees of citizens in numerous cities in Ohio sprang into being to assist in the study and solution of the problem. Federal officials were consulted and the public was kept informed. In 1955 the State Legislature passed a strong law calling for a 2 to 10 year prison sentence for possession of narcotics illegally. The penalty for such possession with intent to sell became 10 to 40 years—and for actual illegal sale, 20 to 40 years.

This broke the back of the narcotics racket in Ohio. Of course, some of the racketeers moved their dirty trade into more easygoing States. But in Ohio, important narcotic violations dropped 80 percent. The Bureau of Narcotics was able safely to reduce its agents in Ohio from 20 down to 3, and to transfer the surplus personnel to other areas where the need was more acute.

Louisiana is another State which dealt firmly with violators. For instance, in 1956 the legislature in that State approved penalties of 30 to 99 years, without parole, probation or suspension of sentences, for anyone over 21 years old who illegally sells or gives, administers or delivers a narcotic drug to any other person who is less than 20 years old.

Several other States, such as Illinois, deserve credit for their effective programs.

Various cities also have followed suit in cracking down on criminals in the narcotics field. These cities include Philadelphia, Seattle, Baltimore, and Honolulu. As for narcotic addicts themselves, Evansville, Ind., declared they are a public menace. Under certain conditions the addicts are subject to imprisonment and fines. However, a judge can be lenient if the addict volunteers and is accepted for treatment in some suitable institution.

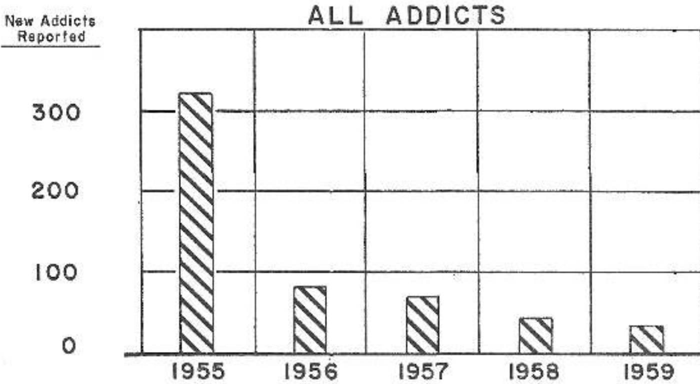
In most parts of the United States, sentences for narcotic law violations have become longer. In the 5-year period of 1950–55 the average length of prison terms for the violators more than doubled. One major remaining step is to apply strict penalties to every part of the Nation.

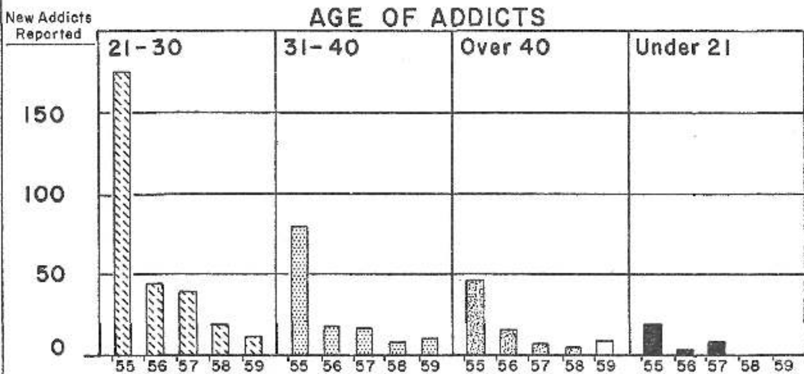
Federal Bureau of Narcotics

RESULTS OF EFFECTIVE LEGISLATION ON DRUG ADDICTION IN OHIO

CALENDAR YEARS 1955—1959

(State law became effective September 1955)





Summary

Opium probably has the longest history of any known drug. For thousands of years it has served well in the medical and scientific field, as have several other narcotic drugs in more recent times. It was not until the last two centuries that there was noticeable awareness of addiction.

In America in the latter half of the 1800's and the early 1900's narcotic addiction mushroomed to an alarming extent.

The Harrison Act, passed in 1914, marked the beginning of a series of laws enacted by Congress to control narcotics. These controls struck at smuggling, at dope peddling and other illicit narcotic activities.

Shortly after World War I experiments with State and city clinics to provide drugs for addicts resulted in a sorry failure. Addiction grew by leaps and bounds and all the clinics closed down.

In 1930 the Bureau of Narcotics began its successful efforts to carry out the controls which Congress had established. States and cities also did similar work and cooperated excellently with the Bureau.

For about 50 years the United States has been working with other nations to carry out international controls of narcotics. In recent years the United Nations and various organizations within its framework have spearheaded notable progress. Groups such as the American Medical Association, the National Research Council, Congressional Committees and others have contributed greatly.

Lately discussion has arisen about the possibility of instituting some new clinics. The main reasons for abandoning this idea include:

1. Clinics failed miserably in the United States and in every other country where they were tried out;
2. Such clinics would clash head-on with our laws, our governmental policies, important court decisions, and positions taken by Congress, American Medical Association, National Research Council, the Bureau of Narcotics, and many others who have studied the situation thoroughly;
3. The clinic idea would violate a whole network of agreements with nearly all foreign countries;
4. Such clinics indicate the maintenance and perpetuation of narcotic addiction.

The principal solutions for prevention and control of illicit narcotic activities consist of:

1. *Compulsory hospitalization of narcotic addicts.* The addict lacks self-control and needs to be confined for a period of treatment and rehabilitation and afterward carefully supervised to head off a relapse or to arrange for new treatment and rehabilitation. Federal hospitals at Lexington and Fort Worth and others run by States or cities have contributed a good deal. But States and cities need to do much work to provide proper facilities and personnel. Public understanding and support are essential to make this possible.

2. *Effective policing is also vital.* This was highly effective prior to the end of World War II. Between the two world wars narcotic addicts in the United States decreased in number from at least 200,000 down to a possible total estimated at 60,000—this in spite of the enormous gain in population.

For a while after 1946 a period of laxness occurred in State and local policing and in the courts. The number of Federal agents was reduced for several years, but finally restored.

In the past few years national, State and local legislation, court action, policing and public opinion all have stiffened. Wherever heavy penalties have been imposed upon narcotic law offenders, the violations have dropped dramatically.

But much effort needs to be exerted to have both the heavy penalties and compulsory hospitalization extended to every part of the United States. Those, together with extension of the other activities now underway, such as continuing research, give the greatest assurance of bringing the evils of narcotic addiction down to an absolute minimum.

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