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# SOCIAL POLICY ON DANGEROUS DRUGS: A STUDY OF CHANGING ATTITUDES IN NEW YORK AND OVERSEAS

CHESTER R. HARDT\* AND RUTH BROOKS\*\*

## HOW NEW YORKERS HAVE DEALT WITH DRUGS

Narcotic addiction is, of course, not new to New York State. From 1850 to 1920 it was dealt with as a medical problem and from 1920 as a criminal problem. What is new, since World War II, is its relative prevalence, its association with the abuse of other drugs, the youthfulness of addicts, and the development of a criminal-drug subculture. What is unique is that for 25 years (1945–1970) New York's policy on this admittedly socio-medical problem was formulated primarily by the U.S. Treasury Department.

### *Early History*

Morphine, an opiate alkaloid, was isolated from opium in 1805. With the invention of the hypodermic syringe in 1853, injectable morphine became the major analgesic of the 19th century. Its use for the pain of wounds was so extensive during the Civil War that morphine addiction was known as "the Army Disease." Heroin was first synthesized in 1874 and in 1898 was introduced into medical practice and actively promoted as a substitute for morphine on the grounds that it did not repress respiration and would be less likely to produce addiction.

Patent medicines containing narcotics were widely consumed in the latter half of the 19th century and by the 1890's Sears, Roebuck's catalog advertised Sears' "Cure of the Opium and Morphine Habit." Until 1903, cocaine was one of the ingredients in a highly popular soft drink.

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The authors, former Chairman and Administrative Assistant to the Chairman of the New York State Temporary State Commission to Evaluate the Drug Laws, participated in a privately funded on-site study of the approaches to drugs in Japan, United Kingdom, Sweden, The Netherlands, Lebanon, and the Federal Republic of Germany in May-June, 1972. The views expressed are those of the authors and not necessarily those of the other members of the Commission.

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By 1912, an estimated 215,000 people in the United States were addicted to a narcotic.<sup>1</sup> Most were middle-class, middle-aged people who had become addicted through medical prescription of the drug. There were about twice as many women addicts as men. Private hospitals admitted addicts for detoxification, and physicians, when necessary, maintained them on withdrawal-preventing dosages.

That year, the United States initiated the Hague Opium Convention, which established international regulation of opium production and the sale, transfer, and use of narcotic products. However, narcotics remained available without medical prescription until enactment of the Harrison Narcotic Act in 1914.<sup>2</sup> This Act provided that all handlers of narcotics be registered, and that records be kept of all transfers; it imposed a special excise tax on the sale of narcotics, and provided a maximum penalty of ten years' imprisonment for violation of provisions. Since the Act was essentially a revenue measure, enforcement fell to the Bureau of Narcotics of the Treasury Department. Although the Act provided that "nothing . . . in this section shall apply: (a) to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician . . . registered under this Act in the course of his professional practice only,"<sup>3</sup> it also noted that the prescription had to be "for legitimate medical purposes" and "prescribed in good faith."<sup>4</sup> Neither of these two phrases were defined. The Treasury Department began investigating physicians who were prescribing narcotics to addicts and promulgated regulations instructing doctors on prescribing and dispensing narcotics. A number of physicians were criminally prosecuted and a series of court fights ensued. In 1922, a Supreme Court decision<sup>5</sup> established that it was a crime to prescribe narcotics for an addict solely to treat his addiction, *i.e.*, unless he had a condition, other than his addiction, which required narcotics. This interpretation of the Act was reversed in 1925, when the Court found that addicts were "diseased and proper subjects for such [medical]

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<sup>1</sup> E. BRECHER, *LICIT AND ILLICIT DRUGS* 62 (1972) [hereinafter cited as BRECHER]. Brecher cites a study by Drs. Lawrence Kolb and A. G. DuMez published in 1924 by the U.S. Public Health Service. See also D. MUSTO, *THE AMERICAN DISEASE—ORIGINS OF NARCOTIC CONTROL* 254 n.13 (1973). Dr. Musto reports that the consensus of writers expert on the U.S. history of addiction is that narcotic addiction peaked around 1900 at between 200,000 and 400,000 and dropped to about 100,000 in the 1920's. Higher estimates after 1920 are believed to reflect increased fear of addiction and of addicts, rather than increased narcotic use.

<sup>2</sup> Act of Dec. 17, 1914, ch. 1, 38 Stat. 785.

<sup>3</sup> *Id.* at 786.

<sup>4</sup> Act of Feb. 24, 1919, ch. 18, 40 Stat. 1057, 1131.

<sup>5</sup> *United States v. Behrman*, 258 U.S. 280 (1922).

treatment."<sup>6</sup> But the "damage" was done. Doctors were reluctant to treat addicts lest they get involved with the Treasury Department.

In 1919-1920, 40 cities opened clinics to provide low-cost drugs to addicts and in their brief existence treated some 12,000.<sup>7</sup> By 1921, all but one (Shreveport, Louisiana) were closed, through the efforts of the Bureau of Narcotics backed by the American Medical Association. New York City had opened a clinic in April, 1919, but security precautions were poor and it was not well-managed. S. Dana Hubbard, M.D., a city health official who disapproved of the clinic, commented "[It] is not the solution — but it aids in bringing the secretive addict out of his lair . . . makes him more friendly and, deprived of his supply, he is willing to be cured . . ."<sup>8</sup> Nevertheless, the clinic closed in January, 1920.

By 1919, illicit traffic had developed. The proportion of addicts who were disadvantaged people from urban slums had increased. When the clinics closed, addict-patients, left to the mercies of the peddlers, became addict-criminals. The states shifted to a strictly penal approach. A police roundup of addicts was initiated. There were 888 federal arrests on narcotic charges in 1918 and 392 convictions. The numbers escalated until their peak in 1925, when production and importation of heroin was prohibited. That year there were 10,297 arrests and 5,600 convictions. Users were prosecuted more often than peddlers.<sup>9</sup>

Despite the police roundups, there was no appreciable drop in addiction until World War II. The use of narcotics and cocaine became common among show business personalities, jazz musicians and other artists. From 1921 to the end of the 1950's there was virtually no treatment for addicts within New York State. There were a few private psychiatric facilities, such as the Hartford Retreat in Connecticut, for those who could afford them, and Charles B. Towns' Hospital in New York City admitted addicts for detoxification.<sup>10</sup>

During the war, supply was cut off, there was full employment

<sup>6</sup> *Linder v. United States*, 268 U.S. 5, 18 (1925).

<sup>7</sup> BRECHER, *supra* note 1, at 116.

<sup>8</sup> A. LINDESMITH, *THE ADDICT AND THE LAW* 144 (1965) [hereinafter cited as LINDESMITH], citing *Hearings Before the Subcomm. on Improvements in the Federal Criminal Code of the Sen. Comm. on the Judiciary*, 84th Cong., 1st Sess., pt. 5, at 1718-19 (1955) [hereinafter cited as *Daniel Subcomm. Hearings*].

<sup>9</sup> Dr. Butler of the Shreveport Clinic, quoted in C. TERRY & M. PELLENS, *THE OPIUM PROBLEM* 864-72 (1928), complained that "through the detective system practiced by the dispensary, many arrests of peddlers were made and evidence sufficient to convict them secured, but . . . these cases when brought into court were either repeatedly postponed or dismissed."

<sup>10</sup> Interview with Henry Brill, M.D.

and a sense of national purpose, and narcotic use decreased sharply.<sup>11</sup> Deaths involving narcotism in New York City dropped to less than 20 per year, from the average of 46 per year in the pre-war period.<sup>12</sup>

*The Post War Years — 1946–1966: The Penal Approach*

After World War II, the use of heroin spread again, especially among low-income Irish and Italian urban workers, Blacks who had migrated from farm to city, and Puerto Rican immigrants.<sup>13</sup> Relations among addicts were characterized by social cohesion and camaraderie.

These were years of social unrest and personal dislocation. Many migrated from country to city, leaving behind the extended families and cohesive communities which had buttressed their lives. Urban housing shortages became exacerbated, schools deteriorated, and the country was involved continuously in overseas military actions and a universal draft. In the 1960's there were race riots, student riots, and police riots.

By 1950, deaths from overdose had risen to 57 in New York City, and sizable numbers of adolescents addicted to narcotics began to come to the attention of officials.<sup>14</sup> The preponderance were poor, and were Black and Puerto Rican. In 1952, New York City opened one treatment center, Riverside Hospital on North Brothers Island, for addicts under 21. But many addicts continued to be jailed, and by 1957 the then New York City Corrections Commissioner, Anna Kross, upon whom fell the full burden of caring for them, was loudly demanding that treatment facilities be opened.

In 1955, the New York Academy of Medicine proposed the establishment of narcotic clinics, to separate the addict from crime. At a hearing on the plan conducted by a Senate Subcommittee chaired by Price Daniel, when the point was made that in England, the medical dispensation of narcotics had not (at that time) spread addiction, Dr. Harris Isbell of the Public Health Service commented, "I merely say that England is not the United States; that social conditions in England

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<sup>11</sup> LINDESMITH, *supra* note 8, at 100. During the war years there were an estimated 48,000 to 60,000 addicts nationwide.

<sup>12</sup> Figures from the N.Y.C. Medical Examiner indicate an average of 46 deaths involving narcotism per year for 1918-1940, in the city, with peaks of 81 in 1921 and 78 in 1924.

<sup>13</sup> Preble and Casey, writing in 4 INT'L J. ADDICTION 1 (1969), note that the cost of heroin then was low, its purity high, and its use not greatly stigmatized, although it had been during the twenties, as accounts of that period indicate.

<sup>14</sup> I. CHEIN, *THE ROAD TO H: NARCOTICS, DELINQUENCY AND SOCIAL POLICY* 32 (1964). From 1949 through 1955, 3,457 males aged 16-20 years were identified as narcotic users, with 500 new cases reported each of those years.

are far different from those in the United States. Apparently we have an addict-prone population."<sup>15</sup> No further discussion of the "social conditions" or the reasons for American "addict-proneness" are recorded. The plan was rejected on the basis of the supposed failure of the 1920 clinics and out of fear that it would create new addicts, fail to end the black market in drugs, cause escalation of addiction, and raise a "grave moral issue."<sup>16</sup>

In the following year, 1956, the Federal Narcotic Drug Control Act was passed, providing mandatory minimum sentences with probation and parole excluded, for all narcotic offenses except first possession offenses.<sup>17</sup> By 1960, 15 percent of the federal prison population were narcotic violators, in contrast to 4 percent in 1946.

At the White House Conference on Narcotic and Drug Abuse, in 1962, James V. Bennett, then Director of the United States Bureau of Prisons, described the disinterest of narcotic offenders in the rehabilitation programs available in federal prisons, and commented "that, of course, is due largely to the fact that they are doing . . . 'flat time,' a sentence without hope of parole or remission no matter how hard they try to better themselves."<sup>18</sup> That same year, the United States Supreme Court affirmed its position that the condition of addiction is not a crime,<sup>19</sup> and the New York County Medical Society again suggested that clinical research with narcotics be permitted.

### *The Beginning of Treatment — 1966–1972*

Meanwhile, from 1957 on, heroin addiction had been infecting increasing numbers of white and middle class adolescents.<sup>20</sup> By the end of the fifties, voluntary drug-free therapeutic communities had begun to open as retreats in which addicts could learn new life-styles, away from the drug temptations of the street. Absent supportive services to

<sup>15</sup> *Daniel Subcomm. Hearings, supra* note 8, pt. 5, at 2035 (remarks of Dr. Harris Isbell).

<sup>16</sup> Lindesmith characterizes the proposal as a carefully worked out plan, with numerous safeguards against abuse, in which clinics were to dispense drugs to addicts pending their complete withdrawal, and would maintain incurables indefinitely. LINDESMITH, *supra* note 8, at 135.

<sup>17</sup> Act of July 18, 1956, ch. 629, tit. I, § 108, 70 Stat. 870 (repealed 1970).

<sup>18</sup> *NEW YORKER*, June 26, 1965, at 52.

<sup>19</sup> *Robinson v. California*, 370 U.S. 660 (1962).

<sup>20</sup> A. Freeman, *The Adolescent Heroin Abuse Epidemic in New York City: 1949—?*, Table IV (paper presented at the 5th World Congress of Psychiatry, Mexico City, Dec. 1, 1971). By 1969, the ethnic composition of the New York City's 15-19-year-old addicts as compared to an assured total of all addicts 15-29 years was: 4,170 white (34.5% of total 12,096 white addicts); 3,830 black (24.7% of total 15,514 black addicts); and 1,484 Puerto Ricans (18.8% of total 7,903 Puerto Rican addicts). Figures provided by the New York City Dep't of Health Narcotics Register, 1964-1969.

smooth re-entry into an "outside" community, some such centers, notably Synanon, proclaimed their intention of creating a self-sufficient community in which reformed addicts could live "forever." Also, Drs. Vincent Dole and Marie Nyswander, working during the 1960's at Rockefeller University, were developing the methadone maintenance treatment modality.

In 1966, New York State moved to regularize the funding and supervision of private treatment under the umbrella of the State Narcotic Addiction Control Commission (NACC)<sup>21</sup> and to establish state-operated treatment facilities. The Act creating NACC also established the concept that one who has committed a crime solely or mainly by virtue of his addiction may receive rehabilitative treatment in lieu of prison.<sup>22</sup>

That same year, penalties for gift or sale of narcotics were increased.<sup>23</sup> Federal penalties for possession were also stiffened.<sup>24</sup> Despite these measures, narcotic abuse continued to spread and narcotic-related deaths to rise.<sup>25</sup> Over half of those who died of narcotic-abuse-related causes from 1961 to 1971 were under 25, and one-fourth of them were teenagers.

With the creation of NACC, there ensued several years of battling over which treatment modality (drug-free therapeutic community, methadone maintenance, drug-free supportive therapy in the addict's own community) was most effective and entitled to a larger share of the funding pie.

In May, 1970, the New York State Legislature and Executive, concerned as to whether existing drug laws were effectively dealing with the escalating drug problem, established the Temporary State Commission to Evaluate the Drug Laws. The Commission mandate is broad and includes the charge:

concern itself with the development of systems of laws and regulations, that optimize the freedoms of the individual and minimize harm to the individual and to society from himself and those

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<sup>21</sup> See N.Y. MENTAL HYGIENE LAW § 208 (McKinney Supp. 1972).

<sup>22</sup> The Act provided that a misdemeanant addict shall be certified to the care and custody of NACC for an indeterminate period not to exceed 36 months and that an addict-felon may be sent to prison or certified to NACC for an indefinite period not to exceed 60 months, at the court's discretion. *Id.*

<sup>23</sup> Ch. 193, [1966] N.Y. Laws, 780, amending N.Y. PENAL LAW § 1751 (McKinney Supp. 1966).

<sup>24</sup> Drug Abuse Control Amendments of 1965, Pub. L. No. 89-71, § 7, 79 Stat. 233, amending 21 U.S.C. § 333 (1964).

<sup>25</sup> In New York City, there were 199 narcotic-abuse-related deaths in 1961; 306 in 1965; 656 in 1968; 1200 in 1970; and slightly more in 1971, as reported by the Office of the Chief Medical Examiner.

around him . . . to provide a consistent application of all knowledge to rational judgments regarding the real hazards and positive potentialities inherent in narcotic and non-narcotic drugs and other chemical substances . . . to provide the executive department and the legislature with comprehensive information on the social, fiscal and health problems associated with narcotics addiction, and drug abuse . . . to study the emerging patterns of mixed drug abuse which complicate present legal approaches . . .<sup>26</sup>

Not until the beginning of 1971, with the availability of much more federal funding, did the debate over the effectiveness of different treatment modalities taper off. New York City moved more aggressively into the treatment field, and in 18 months established 200 methadone maintenance clinics, often in communities resistant to having a treatment center in its midst. Waiting lists are now down to 2-3 weeks in city-run clinics, from the previous 6-month to 2-year wait. Many treatment centers expanded to offer a variety of treatment modalities, tailored to the needs of the individual addict.<sup>27</sup> New problems arose, such as multi-drug abuse, drug abuse by younger teenagers, and employment of rehabilitated addicts.

At that juncture, the Commission decided it would be of value to review the characteristics of and remedies for drug abuse overseas, anticipating that such a study would suggest some new approaches for New York State. Obtaining private funding for such a study, three commissioners and staff, in May-June, 1972, visited Japan, Lebanon, Sweden, the Federal Republic of Germany, the Netherlands, and the United Kingdom, and met with government authorities on law enforcement and with government and private experts in rehabilitation, after-care and prevention.

First-hand observation of the drug picture in other countries quickly confirmed that drug situations overseas, just as here, are more complex than they seem from a distance. There is no "magic pill" for the drug problem. But there are lessons to be learned and applied to New York State.

## HOW PEOPLE OVERSEAS DEAL WITH DRUGS

### *Japan*

#### A. Characteristics of the Drug Abuse Problem.

Large-scale drug abuse in Japan began with that country's defeat in World War II. Until 1945, drug abuse had been limited to some

<sup>26</sup> Ch. 474, [1970] N.Y. Laws 1923.

<sup>27</sup> N.Y.C. HEALTH SERVICES ADM'N REP. (1972). It is noteworthy that in New York City in 1972, treatment for alcoholics rose 50-70% over 1971, with those seeking help doubling.



alcohol (saki and beer) excesses and some opium smoking, mostly by aged Chinese. However, during the war, amphetamine use had been encouraged to increase the speed and efficiency of factory workers producing materiel and to raise the energy level of combat forces. Military defeat brought with it social dislocation, a brief period of thrashing about for a national goal to replace that of victory, and an increase in a variety of deviances, including vagrancy, gangsterism, and juvenile delinquency.

Simultaneously, large stockpiles of amphetamines, originally held for the use of the military, were dumped on a disoriented Japanese population. With no legislation to regulate trade in and use of the drug, its abuse became epidemic, particularly among poorer people. By 1954, the Japanese estimated that two million people had at least experimented with amphetamine or injectable methamphetamine. There were an estimated 550,000 chronic stimulant abusers, with 200,000 suffering resultant mental disorders.

At the same time, stockpiled morphine no longer needed for military medical use was also unloaded on the Japanese. Unauthorized use of morphine never reached the epidemic scope of amphetamine abuse, but the number of narcotic users did peak to an estimated high of 40,000 in 1962, with 2,176 "discovered and reported" addicts. Amphetamines and narcotics trade was taken over by professional "gangsters," who provided heroin from Southeast Asia as a substitute for the depleted supply of morphine. Heroin users were mainly juveniles from impoverished neighborhoods where other deviant activity flourished.

The government responded to this drug problem with a well-coordinated and firm series of ever-more-stringent measures — legislative, law enforcement, and social. The effect was the virtual eradication of the problems of both amphetamine abuse and narcotic addiction as reflected in National Police Agency arrest figures (for amphetamine abuse: 55,664 in 1954 and 1,034 in 1963; for narcotics: 3,169 in 1963 to 266 in 1971) and in the increasing age of abusers and addicts.<sup>28</sup> With the crisis controlled, the percentage of arrestees actually

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<sup>28</sup> With regard to violations of the Awakening Drug Control Law of 1951: A broad round-up of amphetamine abusers yielded 38,500 arrests in 1953 and 55,664 in 1954 (63% convicted), and then arrests decreased, dropping to a low of 271 in 1958. Thereafter, they rose again, gradually at first and then more sharply in 1963, with the tightening of the narcotic laws and a consequent switching from narcotics to injectable methamphetamine, to 1,034. They then leveled off, remaining fairly stable. Since then, a recent slight increase to 1,682 in 1970 is attributed to the fact that prison sentences imposed seven years ago were terminating at that time. In 1963, with more stringent narcotic laws, a broad dragnet arrested 3,196 addicts. By 1971, although law enforcement continued to be vigorous, arrests were down to 266. The number of new addicts reported in 1970 was 63, all using mor-

imprisoned dropped from 70–80 percent in 1963 to 36 percent in 1971. “Minor” cases are instead given medical care.

#### B. Legislative and Administrative Measures.

By 1949, the government moved to counter the drug epidemic by letting it be known that officialdom considered amphetamines poisonous and did not wish the population to use them. The Ministry of Health and Welfare informed pharmaceutical manufacturers that it considered overproduction of amphetamines undesirable and against the public good.

In 1951, these attitudes were crystallized in legislation. The Awakening Drug Control Law of 1951 restricted the use of stimulants to medical treatment and research and restricted their manufacture to firms designated by the Minister of Health and Welfare. 1954 amendments provided for compulsory hospitalization of amphetamine “addicts” and for control of the manufacture of precursors of amphetamines. Further amendments in 1955 provided increasingly severe penalties for violation of the law. The setting of quotas as part of a manufacturing license was also provided. The amount of amphetamines produced under a quota in Japan can be very small, because amphetamines are used medically there only for narcolepsy. They are not prescribed for weight reduction or hyperkinesis. Hyperkinetic children are treated with psychotherapy.

In 1953, the Narcotic Control Law was passed restricting the use of any narcotic to medical treatment and scientific study and requiring a license for its use. This law was not made more stringent until 1963, at which time it was amended to provide that there be a system of notification by citizens to the authorities of infringements of the law and that penalties be raised to a maximum of life imprisonment for sale.<sup>29</sup> Provisions of the Mental Hygiene Law were extended to allow for compulsory hospitalization of narcotic addicts. In 1970, LSD was designated a narcotic.

Additionally, a cabinet level steering committee was formed in 1955 to coordinate anti-amphetamine-abuse efforts, and another in 1962 to coordinate the national campaign against narcotics addiction.<sup>30</sup>

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phine except for those who became addicted to other medically prescribed narcotics. By 1970, there were no known users of heroin. The age of addicts increased and by 1966, 61% were 50 years or older, compared to 1962, when 75% were 20-40 years old.

<sup>29</sup> According to Mr. Nakamo, Vice-Chairman of the Executive Council of the Liberal-Democratic Party, there was broad support for instituting a death penalty at that time.

<sup>30</sup> These cabinet committees unified the efforts of the Ministry of Justice, which handles all drug cases, juvenile and adult; the Ministry of Finance, involved through its

This coordination of effort is one of the most outstanding characteristics of the campaign against drug abuse in Japan.

Also of importance in eradicating the drug problem was the dramatic rise in the availability of employment which is part of the post-war recovery and present economic prosperity of Japan. In 1951, there were two people for every job. By 1957, there was full employment and from 1962 to the present there has been a labor shortage.<sup>31</sup> Japanese officials consider this an important factor in their success in wiping out abuse of narcotics. In their view, a major cause of narcotic abuse was unemployment and people's consequent sense of hopelessness and purposelessness.

### C. Law Enforcement.

A suspected user of stimulants or narcotics can be arrested on suspicion of use, if there is some evidence of prior possession. It is not necessary that he have contraband in his possession at the time of apprehension. In contested cases, to determine addiction, two psychiatrists examine the prisoner, who has the right of appeal to a court. If found to be addicted he is sent either to a hospital or prison, at the discretion of the judge. Possession not for gain carries a penalty of imprisonment with labor for a term not more than 10 years for narcotics and 5 years for amphetamines, or alternative hospitalization.

The ability to round up large numbers of drug users, when the government desired to do so, was enhanced by two things: an attitude of concern and involvement on the part of the Japanese "man in the street," so that most will take the responsibility to report to the police someone who appears intoxicated; and the National Police Agency regulation that each policeman must live, with his family, in the area to which he is assigned. Each police officer, therefore, has a "province" of people with whom he is familiar, to whom he can talk, and whom he knows where to find.

Informing the police is common, although there is no bounty system, and the usual police procedure after their attention has been focused on a suspect by an informer is to "shadow" the suspect and then obtain a warrant of arrest. The police have no undercover agents. They may hold a suspect for questioning for 48 hours, and for an additional 24 hours by order of the Prosecutor, to determine the

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Customs and Tariff Bureau in checking contraband importations; the Ministry of Health and Welfare, which licenses manufacture and records medical dispensing; the National Policy Agency; and Public Education, which is directly under the authority of the Prime Minister.

<sup>31</sup> Interview with Dr. Suto, staff member of the United Nations Far East Asian Institute.

validity of charges; and for another 20 days upon court order for further investigation. After this 23-day period, the suspect is either indicted or released. Those indicted for trafficking for gain are almost always held without bail from time of arrest to day of imprisonment, as is allowed under Japanese law for those accused of a crime punishable by a minimum of more than one year in prison.

Narcotics smuggling, which flourished in the early 1960's, was controlled exclusively by established racketeers.<sup>32</sup> In 1964 and 1965, the police mounted a concerted drive, "Operation Chojo Sakusan," against smuggling of narcotics, in cooperation with the Customs Bureau, and against trafficking in amphetamines, illicitly-manufactured domestically. Smuggled contraband enters by mail, in cargo, and on the persons of crew and passengers.<sup>33</sup> Top priority went to arresting top-level criminals, second to wiping out the "underlings" in a broad dragnet. On a second offense for smuggling, the sentence was doubled.

This operation was eminently effective and since that time there has been virtually no smuggling of narcotics. The risk was too great and, since there had been a simultaneous roundup of users, the market for narcotics was wiped out. Presently, most of the smuggling is of contraband brought in for personal use, not sale, and involves one person, not a gang.

Such an effective program implies the absence of a corrupt connection between police and criminals. There is administrative coordination of efforts of the police in each prefect, because the National Police Agency supervises all local police. Each police station has a Narcotic Officer who works closely with those assigned to cover racketeering.<sup>34</sup>

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<sup>32</sup> There are 3,214 "gangster groups" in Japan according to the National Police Agency, each of which is known to the police and under their surveillance with varying intensity. These "gangster groups" usually make their money in gambling, "protection" (of bars, usually), and trafficking in illegally manufactured stimulant drugs.

<sup>33</sup> Cannabis comes into Japan from the United States, the Philippines, Canada, and Korea. In 1970, 15 kilograms of cannabis were seized in a total of 68 cases. The quantities seized were relatively small, the largest single seizure being 210 cigarettes. Amphetamines come into Japan from Korea and the Philippines. They are made in Korea. The largest single haul was 17.5 kilos coming from the Philippines. Heroin comes in from Hong Kong, Malaysia and Indonesia. Seizures were as follows: in 1970, 2.1 kilos (six cases); in 1971, 0.25 kilo (one case). Opium is smuggled in mostly by foreigners. In 1970, three kilos were confiscated; in 1971, less than one kilo. LSD comes in from the United States and France, and there were 45 arrests for smuggling LSD in 1971, 70% of whom were U.S. citizens.

<sup>34</sup> There were, as of May, 1972, 860 Tokyo police assigned to narcotic and stimulant control (New York City had 600) to cover a population of 11 million. Police receive one year of training, which includes some training in the law, and continue advanced training to qualify for promotion. With full employment, the desirability of appointment to the police force is diminishing and police now consider themselves under-paid.

The Ministry of Health and Welfare controls the dispensation and prescription of amphetamines and narcotics and their narcotics agents inspect doctors' records. There has been some illegal prescription of morphine and codeine, but no diversion of legally manufactured amphetamines.

#### D. Treatment and Detention.

The twin keystones for treatment in Japan are enforced abstinence for a short period of time, usually in a hospital or prison, followed by supervised return to the community.

About half of those arrested for amphetamine abuse in the sweep of 1953 and 1954 (38,500 and 55,664, respectively) were found to be "addicted to" amphetamines. Four thousand were admitted to mental hospitals in 1954, and 1200 in 1955. In hospitals, treatment consists mainly of individual and group psychotherapy. Many amphetamine abusers were persuaded to drop their drug habit simply by the threat of harsh prison sentences or involuntary hospitalization, and by personal informal persuasion by police or neighbors. By 1956, the number hospitalized that year had dropped to 300, the Ministry of Health and Welfare reports.

For narcotics addicts, 650 beds in 9 communities were put aside in anticipation of need, just *prior* to enactment of the 1963 regulations. Only 200 were used, however, and hospitalization was usually for no longer than a 3-month period, although a maximum of 6 months is allowed by law.

Methadone is not used in hospitals or prisons to ease withdrawal pain, although it is legal to prescribe it. Rather, the suffering which accompanies unmedicated withdrawal is dramatically exploited to serve as a public warning.

Upon release from a hospital or prison, each addict (whether a narcotic or amphetamine abuser) is assigned a volunteer counselor (probation officer). There are 207 such counselors in Japan at present. They are considered a most important part of the effort to rehabilitate and to prevent back-sliding. They supervise people who live in their own village or, in the large cities, in their own neighborhood. They are citizens of stability and substance. They assist the addict in his reintegration into his community following release from hospital or prison. They help him obtain needed government aid (in finding a job, providing for initial housing, clothing, and food needs), and give guidance to him and to his family.<sup>35</sup> Narcotic addicts remain

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<sup>35</sup> According to a 1966 Ministry of Health and Welfare publication, 6,125 addicts were

under supervision for many years. The criteria for discharge from this volunteer probation status require that the probationer demonstrate, for at least five years, maintenance of a life style which is socially acceptable in all aspects and total abstinence from drugs. Therefore, although the recidivism rate after release from hospital is almost zero, a 1969 review of all probationary addicts revealed only 52 out of 5,435 had been released from probation.

Possessors of cannabis, who face a penalty of imprisonment with labor for not more than five years, may be compulsorily hospitalized at the discretion of the judge. Although the Japanese consider that marijuana use leads to the use of LSD and is therefore dangerous, hospitalization is not enforced, according to the Minister of Justice.

Alcoholism, a constant but not widespread problem, is covered by the Mental Hygiene Law, and alcoholics may be, and sometimes are, compulsorily hospitalized by the Ministry of Health and Welfare. There has been some increase in alcoholism with the tightening of narcotic and stimulant laws.

#### E. Education.

The Japanese consider education of the public to the dangers of drug use so important that a cabinet level position directly responsible to the Prime Minister was created to coordinate drug education. It is viewed as part of total health education in the schools and is approached as part of learning the proper use of medication.

In addition to compulsory courses in the schools, the Prime Minister launched educational campaigns in the press, on radio, and through lectures and symposia. The Japanese, adults and children, give great weight to information from experts and those in positions of authority.

#### F. Present Situation.

At present, amphetamine use is again on a mild rise among non-conformist young people, who take them for "fun." The drug is no longer used by factory workers or others under stress of production quotas.

Two problems now emerging as major are sniffing of solvents, such as glue, and abuse of barbiturates and non-barbiturate tranquil-

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seen at least once that year by a volunteer probation officer (an average of 29 addicts per volunteer). Mr. Atsushi Nagashima, Director, United Nations Far East Asian Institute, indicated many of these volunteers are now older people and the number of younger adults interested in rendering this kind of service is diminishing.

izers. Solvent sniffing is now an offense only under prefectural ordinance. In 1969, the latest year for which figures were available, 61 youths died in connection with glue and other solvent sniffing. The police are handling this now on a local basis, "giving guidance" to juveniles (31,028 were reported as receiving such guidance in 1969). Japan, as of May, 1972, was drafting a national law covering solvent sniffing.

Estimates are that 1 percent of the population uses barbiturates regularly. Barbiturates are regulated now only by the Pharmaceutical Law, but abusers may be hospitalized and then receive follow-up care by voluntary supervisors. Treatment of barbiturate abusers has been less successful than that of abusers of other drugs because barbiturates are still so easy to obtain, and because abusers of them tend to be loners and therefore less susceptible to the deterrent pressures of family and neighborhood.<sup>36</sup>

The most popular depressants are by far the non-barbiturate tranquilizer-hypnotics.<sup>37</sup> Fifty-eight percent of the abusers resided in Tokyo in a 1963 survey, and 58 percent were high school students. Intensely competitive examinations for admittance to high school and to university cause great anxiety in that age group and failure is one causative factor in student suicides.

#### G. Comments.

The most striking qualities of the Japanese approach to eradicating drug abuse are their single-mindedness of purpose, clarity of official message, speedy action, and coordination of efforts. These qualities are central to the effectiveness of the Japanese campaign. For instance, once the policy decision was made by the central government that illicit use of drugs had to end, no consideration of other factors, such as the impact this would have on the profits of pharmaceutical manufacturers, or on the right of a private citizen to ingest what he chooses, was allowed to impinge. Action was consistent with stated policy. Penalties were raised and involuntary hospitalization initiated *immediately*, while the drug problem was still young.

Additionally, the campaign against drug abuse took place during

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<sup>36</sup> Interviews with Mr. Nakamo, Vice-Chairman of the Executive Council of the Liberal-Democratic Party, and Mr. Kokichi Higuchi of the Ministry of Justice.

<sup>37</sup> Kato, *An Epidemiological Analysis of the Fluctuation of Drug Dependence in Japan*, 4 INT'L J. ADDICTION 601-04 (1969). In a survey of 835 patients treated in mental hospitals, methaqualone and meprobamate seemed the most commonly used. Another survey determined that between 1961 and 1962, 1,942 arrested youths abused methaqualone (Quaalude and Sopor in the U.S., Hyminal in Japan).

a period of dramatic change in the economic situation and in housing availability. Unemployment was eradicated and a program of urban renewal did much to wipe out slums, and thus the potential market for heroin was narrowed.

Prominent characteristics of the Japanese culture which aided their anti-drug-abuse efforts include:

1. The closeness and strength of family ties. There is no word in the Japanese language which means family breakdown. (There has been, in recent years, some loosening of the ties between children (particularly sons) and parents, and officials think this contributed to abuse of drugs).

2. The emphasis which is placed on respect for authority, following instructions, conforming to the group, and working in committee, with negative values placed on individualism, personal creativity and innovation.

3. A very strong sense of community, which includes a real acceptance of each Japanese person as part of the nation and the neighborhood, and an acceptance of responsibility by each resident for the welfare of his community and its other members. From this flows citizen involvement in identifying addicts and helping an ex-addict reintegrate into his community.

Although the treatment of drug offenders is decisive and harsh, it is as truly individualized as is their treatment in England. Whether the motivation is to protect the state or to help the individual offender, the Japanese welcome back an ex-offender who is released from jail or a hospital and involve themselves in meeting his needs for housing, employment, clothing and food. They act on a perception of continuing responsibility to take care of each other and to help each to take care of himself. Certain behavior they will not tolerate; but the perpetrator is still "one of us." With wisdom, they recognize that problems are not solved overnight and that a strong arm and watchful eye available over a long period of time are most effective as a deterrent to straying from a new-found path of constructive behavior.

Japan is facing certain relocations and temporary dislocations through its rapidly expanding industrialization and increasing urbanization. Problems exist, including abuse of dangerous drugs, such as depressants and solvents, and the Japanese are moving to overcome these by the same unity of purpose and coordination which has worked so well to now.



*United Kingdom*

## A. History and Characteristics of the Drug Abuse and Addiction Problem.

In 1926, The United Kingdom appointed the Rolleston Committee to study the quality and extent of addiction among the several hundred narcotic addicts then in England. At that time, those addicted were mainly middle-class, middle-aged people who had become addicted to narcotics which had been prescribed for them originally for the relief of organic pain. The Committee reported that opiate addiction is the manifestation of an illness and "not a mere form of vicious indulgence," and that it should be dealt with medically. This viewpoint was generally accepted and set the direction of the approach to addiction in the United Kingdom.

In 1961, although the number of addicts known to the Home Office was still under 500, a commission chaired by Sir Russell Brain was appointed to review the findings of the Rolleston Committee. This commission reaffirmed the Committee's findings and concluded that no new controls were necessary.

Between 1960 and 1965, however, a change took place in the numbers and characteristics of the British narcotic addicts, due to the prescribing patterns of about six physicians, who became known and popular among addicts as generous prescribers. This handful of physicians prescribed a superabundance of narcotics to their patients, who, in turn, initiated their friends by sharing these euphoria-producing drugs with them.

By 1965, the number of addicts had doubled and many were addicted to heroin, rather than morphine. Those addicted were younger and began to include juveniles who had been in trouble with the law before their addiction.<sup>38</sup> Addicts began abusing a number of different drugs, in combination with heroin or separately, and so did some non-addicts. Some multi-drug abusers were arrested for crimes.

Aware of the growth in number of addicts and of their increasing youthfulness and beginning poly-drug abuse, the Brain Commission reconvened in 1964. This time it recommended that the number of doctors authorized to dispense heroin and cocaine be limited, that reporting of addicts to a central authority be mandated, that treatment

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<sup>38</sup>In 1959 there were only 35 addicts under age 34; by 1965, there were 259 addicts under age 34, 40 of whom were under age 20.

centers be established within the psychiatric departments of general hospitals, and that addicts be subject to compulsory detention.

Meanwhile, also in 1964, action to end the abuse of amphetamines and LSD was initiated both statutorily, through the Drugs (Prevention of Misuse) Act,<sup>39</sup> and voluntarily, by agreement of medical practitioners to prescribe amphetamines cautiously, mainly for narcolepsy and as an adjunct in the treatment of selected cases of childhood psychiatric disorders accompanied by hyperactivity. Its use in the treatment of obesity was largely discontinued.

In 1967, the second Dangerous Drugs Act was passed, controlling the dispensation of narcotics and cocaine and embodying the recommendations of the Brain Commission except that of compulsory treatment.<sup>40</sup> Additionally, the Advisory Committee on Drug Dependence was established as a permanent body to review and recommend policy related to drug abuse.

In 1968, 17 clinics were opened, 14 in London and 1 each in Birmingham, Liverpool, and Manchester. In all, five hundred physicians, all psychiatrists, were licensed to prescribe and dispense heroin.<sup>41</sup> Since the clinics were, and are, the only dispensers of heroin, virtually all known addicts flocked to them. Illicit heroin (previously diverted from physicians) became scarce and its price on the street market jumped from one pound to six pounds per 60 milligrams. By 1969, the number of cases of new addiction was only 3.5 percent higher than that of 1968, although from 1960 to 1968 there had been an average 50 percent increase in newly addicted persons each year. The number of criminal convictions involving heroin use decreased, by 1970, and the amount of heroin legally manufactured decreased and has continued

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<sup>39</sup> The Drugs (Prevention of Misuse) Act 1964, c. 64, defines the circumstances under which amphetamines and LSD may be possessed and provides a maximum penalty of two years' imprisonment for violation of its provisions. The Dangerous Drugs Act 1965, c. 15, regulated import and export of substances, including cannabis and opium and their derivatives, as per the United Nations Single Convention.

<sup>40</sup> The Dangerous Drugs Act 1967, c. 82. This Act restricts the prescription or dispensation of heroin or cocaine for purposes other than the relief of organic pain to physicians especially licensed by the Home Secretary to so prescribe or dispense; mandates physicians to notify the Chief Medical Officer of the Home Office of known or suspected addicts using drugs on Schedule I of the United Nations Convention; and authorizes the establishment of treatment centers with the psychiatric services of general hospitals. Clinic patients receiving social services but not medication are not reported. This Act defines cannabis as a narcotic and provides a maximum penalty of ten years for violation of its provisions.

<sup>41</sup> Physicians practicing outside of London were licensed simply to be on hand to treat addicts, if ever needed. 80% of the addicts in Great Britain are in London. There are 20-30 addicts in each of the other three cities mentioned. The number of addicts scattered throughout the rest of Great Britain is negligible.

to do so. This is an accurate indicator of the amounts of heroin prescribed because all heroin used legally is domestically manufactured.

With the tightening of the narcotics laws, there came an epidemic of intravenous use of injectable methamphetamine in 1968. This brought on a wave of violent behavior, the only substantial drug-related crime Great Britain has suffered. In 1968, there were 400 "speed freaks" in prison for crimes of violence. Accordingly, Burroughs-Wellcome, the one British manufacturer of injectable methamphetamine, agreed to supply this drug only to hospital pharmacies, making it unobtainable except for in-patient dispensing. The cessation of intravenous use of methamphetamine was sudden and complete. By 1969, there was not one such "speed" user in prison.<sup>42</sup>

From 1968 to 1972, about 3000 addicts had been reported to the Home Office, with the number of known addicts at any given time remaining stable at about 2000, approximately 1400 of whom were on narcotic medication. Although the administrative measures and changes in medical practice checked the spread of addiction from over-prescribing, the shift in addict population to a younger age group continued and the presence of a small black market became evident.<sup>43</sup> Males outnumbered females by four to one. Addicts came from families of all social classes, but a very high percentage came from emotionally deprived backgrounds and many had been involved in anti-social behavior from childhood on.

The Misuse of Drugs Act was passed May, 1971 and is an attempt to codify the 1964 laws controlling amphetamines and LSD and the 1965 and 1967 Acts controlling cocaine, cannabis, and narcotics.<sup>44</sup> It gives broad and unusual powers to the police to stop and search people on suspicion of possession of drugs, but exercise of these powers created a backlash. People charged the police with harassing youth and therefore damaging youth-police relationships. It provides three schedules of drugs and for administrative rescheduling of drugs.

There are indications of change in the picture at present. Beginning in 1971, the treatment clinics shifted emphasis from the limited goal of prevention of crime and/or personal disintegration by dispens-

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<sup>42</sup> Interview with C. G. Jeffery, Chief Inspector, Drugs Branch, Home Office.

<sup>43</sup> As of December, 1970, only one-sixth of the heroin addicts known to the Home Office had become addicted through medical prescription. Over 50% of them were younger than 25 and more than 70% were younger than 30. An estimated 250 leave the addict population each year by death or by successful independent drug-free functioning, and an equal number are initiated into drug use by gifts from addicts or through the illicit market.

<sup>44</sup> The Misuse of Drugs Act 1971, c. 38.

ing heroin, to that of weaning addicts from heroin. With this policy change has come some expansion of a black market in heroin, which is smuggled into London from the Crown Colony of Hong Kong, usually by United Kingdom nationals who migrated from Hong Kong to London. Some patients supplement their prescribed rations of methadone or of heroin with black market heroin, as well as with barbiturates and alcohol. Some drug experts suspect that some young addicts now rely completely on illicitly obtained heroin, not registering at clinics out of fear that the physician would prescribe methadone rather than heroin. This suspicion is not yet borne out by evidence. Of the 98 drug-related deaths in 1971, 94 were people who had been known to the Home Office as addicts, suggesting that there is a very small number of non-registered addicts trading only on the black market.

Another major change in treatment has been the growing recognition of the part played by social factors in the misuse of drugs and the conviction that the cure cannot be provided by medicine alone.

Although the number of heroin addicts is now stabilized, there is growing intravenous use of barbiturates, sometimes in combination with narcotics, and this poses a serious medical problem.<sup>45</sup> Barbiturates are available with prescription and are regulated by acts dealing with medicines<sup>46</sup> and an abuser is subject, of course, to the provisions of the Disorderly Persons Act.

Of greatest concern to British authorities is the growth of multiple-drug abuse. Some of the young nonconformists of London are using hashish, LSD, and methadone, as well as barbiturates and some amphetamines. Some high school-age students take small quantities of amphetamines to "pep them up" for a social event. Some take cannabis as a relaxant and some use it as part of a "mystic-religious scene." The drug used by these students which most concerns the authorities is LSD. LSD is the only drug illicitly manufactured in Great Britain and its use has been difficult to control.

#### B. Law Enforcement and Administration.

Administratively, all drug-related problems are under the jurisdiction of the Drugs Branch of the Home Office, whose broad respon-

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<sup>45</sup> T. H. Bewley, M.D., of Lambeth Hospital, told us on June 9, 1972 that there are in London about 350 barbiturate addicts who are "constantly in and out of hospitals. . . . They are a very troublesome group, constantly overdosing, developing abscesses and other medical problems, and prone to accidents. . . ."

<sup>46</sup> Pharmacy and Poisons Act, 23 & 24 Geo. 5, c. 25; The Medicines Act 1968, c. 7.

sibilities include the lower courts, police, probation, and prisons.<sup>47</sup> The name of each addict reported is placed in a card file, and, in addition, Drugs Branch inspectors canvass private agencies to triangulate on the accuracy of their files. These inspectors provide a current picture of the drug "scene," including changes in popularity of different drugs and fluctuations of the illicit market.

The information compiled by the Home Office is available to researchers. England has a long tradition of such research and although investigators must sign a declaration promising not to identify individuals, there is no real fear of indiscretion.

Supervision of the medical profession's adherence to provisions of law is carried out by the General Medical Council, a professional body which functions as a tribunal in cases of possible infractions.<sup>48</sup> Physicians involved in the treatment of drug abuse meet monthly to exchange ideas and experiences.

The police generally concentrate on finding the sources of supply of illicit drugs, but police attitudes vary, and it is easier, there as here, for a police officer to pick up a longhaired young drug user than "to do the hard work of finding the drug supplier."<sup>49</sup>

British magistrates take into account all aspects of a defendant's situation, including social problems, psychiatric condition and family background, as well as the amount of drug found in his possession, in determining disposition. Magistrates insist upon assurance that a defendant will be received into a clinic providing adequate care before they release him on parole, or even before they deport him. For in-

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<sup>47</sup> The Drugs Branch, established in 1920, is the body responsible for compliance with the United Nations Convention on drugs. It operates under the aegis of the Home Office, within its Department of Probation and After-Care. Peter Beedle, Assistant Secretary of that Department, explained that the Home Office itself was originally established as a channel of communication between the commoner and the Crown and to protect the citizen's civil liberties. Its ethos, he said, is therefore basically civil libertarian. The specific responsibilities of the Drug Branch include: (1) shaping the law to meet the needs of a changing drug situation; (2) supplying coordination between health administration, education, and medical research and advising the Crown and government leaders; (3) servicing the staff needs of the Advisory Council on Drugs; (4) supervising the flow of legal drugs from point of manufacture through distribution to the ultimate user; (5) maintaining close liaison with customs officers and with the police; and (6) collecting statistics.

<sup>48</sup> The Council did recommend revocation of the licenses to prescribe heroin for other than the relief of organic pain of several physicians for overprescribing. Only one doctor was investigated for failure to report addicts to the Home Office, and in that case it was determined there had been no willful wrongdoing. The Home Office is aware, however, that a few doctors are still somewhat hazy about the parameters of this responsibility, and queries concerning it are still occasionally received.

<sup>49</sup> Interview with C. G. Jeffery, Chief Inspector, Drugs Branch, Home Office, June 8, 1972. The United Kingdom has 50 local police departments, each autonomous and subject only to advice and guidance from London. There are no national police.

stance, a magistrate recently took the trouble to make arrangements for a young American's acceptance into a treatment clinic in his home town before ordering his deportation.<sup>50</sup>

### C. Treatment.

The Advisory Committee on Drug Dependence stresses the importance of total rehabilitation, including education, housing, and employment, and defines the aims of rehabilitation as the education of an addict to function adequately without drugs. In pursuing this aim, British doctors are up against the extent of addiction to the needle itself.<sup>51</sup> There are shifts in popularity from one substance to another, reflecting changing stringency of laws governing each, but consistently the British addict takes his drug intravenously and as frequently as possible.

For this reason, the goal of the treatment centers was originally social rehabilitation, with or without drugs, and to encourage an addict to inject something less dangerous than heroin and unsterile water.<sup>52</sup> The hope is that provision of drugs until such time as an addict can give them up will be only a temporary tool to help establish rapport, and that then social work, persuasion, and job adjustment will effect full rehabilitation. As the age at which people become addicted has dropped, there has been increasing emphasis on speeding the addict to abstinence. It is only reluctantly that a physician recognizes that a given addict may require narcotics indefinitely, and increasingly it is the older addicts who are more likely to be on a heroin maintenance program.

The success figures for all London clinics, one physician estimates, are as follows: 20 percent of the addicts become drug-free and function as part of the general community; 40 percent function well in terms of social criteria, but remain on drugs; and 40 percent are not able to function well socially and remain on drugs. Of these, he said, "We feel it our responsibility to look after the people whom we cannot cure.

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<sup>50</sup> According to the Narcotics Committee of the United States Embassy in London, 155 United States citizens were arrested in London in 1970 for crimes associated with drugs. Each arrest is reported to the United States Consul.

<sup>51</sup> This was noted by A. Sippert, M.D., of the Department of Health and Social Security, by P. H. Connell, M.D., of the Bethlehem Royal Hospital and the Maudsley Hospital and by B. R. Searchfield of the Community Drug Project, who described the elaborate ritual associated with the process of heating the heroin, mixing it with water, drawing it into the syringe, tying the tourniquet, and finding a vein.

<sup>52</sup> Although addicts on intravenous methadone may inject as frequently as do those on heroin (if they can wheedle sufficient dosage to do so) despite the fact that the effects of methadone last longer, at least the methadone comes in a sterile ampule and does not require dilution.

We give them their medication, and we deal with complications in their lives as they come along. They have a right to health care just like anyone else."<sup>53</sup>

All medical programs, including drug programs, are part of the National Health System, but supportive services to supplement the work of the medical clinics, such as halfway houses and day centers, are all provided and operated by voluntary philanthropic agencies. The government moves cautiously into expenditures for nonmedical programs whose social benefits are not yet proven, preferring that the experimental projects be carried out with private funds.

Many social services are provided addicts by programs which also serve non-addicts, and there is an effort made to help the addict merge, in his employment and housing, into the general community. There is a tendency to give addicts intake priority in programs, and the complaint is heard, "You have to get on drugs to get help."

The backbone of treatment delivery is the clinic but there is a variety of modalities. In London, each of the 14 medical treatment centers (many of which were treating alcoholics before they began absorbing drug addicts) services 60-120 patients and the clinics in Birmingham, Liverpool, and Manchester each have 20-30 addicts in treatment. Elsewhere in the United Kingdom, addicts are treated in the psychiatric services of general hospitals. Staffs include psychiatrists and social workers or psychiatric nurses, and were drawn largely from those who had had experience working with alcoholics, when the clinics were first opened in April, 1968. The ratio of staff to patients varies widely.<sup>54</sup>

When a new patient comes to a clinic, care is taken to ascertain whether he is physically addicted and the extent of his habit, and to evaluate with him whether he wishes to attempt complete withdrawal from drugs. This intake process can take quite a while (at St. Mary's the diagnostic work-up takes at least five weeks), and during this time no medication is prescribed. Medication is eventually prescribed for those who require it, and, again at St. Mary's, only 50 percent of the patients do. Medication varies, depending on the judgment of the staff and the wishes of the patient. Some patients are given chlorpromazine while withdrawing from drugs; some receive methadone during a detoxification period. Those who want to try "cold turkey" are encour-

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<sup>53</sup> Interview with T. H. Bewley, M.D., Lambeth Hospital.

<sup>54</sup> One clinic visited, the St. Mary's Hospital Drug Dependence Center in London, had one staff member for every ten patients, and was able to provide very personalized attention. Others, we were told, had only one social worker for 120 patients.

aged to do so and given a great deal of support in the form of empathy and help with social problems. A patient may move back and forth from one treatment to another. Failing at "cold turkey" he may receive heroin medication, and later "try again."

For those who require medication, there has been a strong trend from 1971 on, to substitute methadone for heroin, although there are differences of opinion among the medical profession on this score. In 1968, heroin was prescribed for maintenance three times as frequently as methadone. As of June, 1972, the ratio was reversed.<sup>55</sup>

Prescriptions are never handed directly to an addict. They are mailed to the pharmacy nearest his home, and he receives his daily supply from the pharmacist. He does take it away with him to self-administer as he chooses. The mean daily dose of heroin prescribed is 134.9 mg., although 600 mg. (10 grains) per day is not uncommon and the range is 10 mg. to 1140 mg. The addict and the physician are in a constant tug-of-war about the amount dispensed, with the addict attempting to obtain larger amounts of medication, and the physician trying to hold him to as small a quantity as he can without pushing him into buying on the black market. The physician faces the dilemma of not wishing to prescribe for one who might be able to become drug-free, on the one hand, and not fostering the growth of an illicit market and exposing the patient to the dangers of adulterated drugs on the other.<sup>56</sup> Illicit heroin is adulterated and the addict therefore does not know what quantity he has in his needle, and fatal accidents are more likely to occur. The balance is struck through a process of in-

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<sup>55</sup> According to A. Sippert, M.D., Chief Medical Officer, Department of Health and Social Security, the medical profession is aware that methadone is not per se less dangerous than heroin, but it has certain advantages, in the opinion of some medical consultants. They are as follows:

1. Methadone comes in ampules and is sterile, and need not be mixed with water. (Although sterile water is prescribed along with heroin, addicts continue to use anything from gutter water to toilet water in preparing their injections).
2. The effects of methadone last longer (although this does not necessarily guarantee that the addict will inject fewer times per day, as noted earlier).
3. It is less of a psycho-motor retardant.

Methadone is not used in blockading dosage for maintenance, as it is in this country. The usual prescription is 60 to 80 milligrams per day, sometimes as little as 10 milligrams. There are a few addicts receiving very much higher doses (two taking 1300 milligrams a day—more than ten times the usual maintenance dosage in New York. These patients are both from Canada, where they built high tolerance levels). Patients are encouraged to progress from injecting methadone to swallowing it in a preparation called linctus.

<sup>56</sup> Interviews with P.H. Connell, M.D., The Bethlehem Royal Hosp. and the Clinical Research and Treatment Unit of Maudsley Hosp., and A. Cahal, M.D., Medical Advisor to the Home Office, June 8-9, 1972. See also Stimson & Osborne, *A Survey of a Representative Sample of Addicts Prescribed Heroin at London Clinics*, 22 BULL. ON NARCOTICS 16 (1970).



dividual bargaining, or "horsetrading." The aim in treatment, according to one physician, is "to make this whole process boring," to make it as unromantic and unglamorous as possible so that "it becomes simply more fun to take alcohol or cannabis."<sup>57</sup>

Eventually, most addicts stabilize their dosage, whether the drug be heroin or methadone, by finally "settling" for enough medication to avoid withdrawal pains, and giving up the attempt to take enough to produce euphoria. Among the 40 percent who do not succeed in functioning socially, some continue to elevate their doses, sometimes to the lethal level, causing death. Others level off their required dosage for reasons unknown to the medical profession. In at least one hospital, St. Bernard, methadone is used for detoxification, but no one is maintained on narcotics. Tranquillizers are given, and treatment emphasis is on group therapy. The average length of stay is three months.

M. M. Glatt, M.D., Director of the Drug Dependence Service, finds that persons sent by the court do better than those who volunteer, and that the addict, ambivalent as to whether he should use drugs, responds better to treatment when he is made to understand clearly that he should *not* use them. Dr. Glatt complained that outpatient programs refuse to take his drug-free released patients for supportive services unless they revert to heroin use. Then medication is often prescribed, thereby negating the progress made in the hospital, instead of reinforcing it with preventive social help.

When an addict is imprisoned, he is given methadone for detoxification, and, once detoxified, remains drug-free during his imprisonment. Upon release, many attempt to remain drug-free. Those who fail return to a clinic. Some physicians urge that therapy be initiated in the prisons, as a start toward rehabilitation.

Much interest has been aroused in the United States over the medical treatment of addicts in Great Britain by dispensing heroin to them. In considering whether any part or all of the British methods of treating drug abusers can and should be used in this country, it is important to recognize the different context in which the medical profession functions in Great Britain and also the differences between addicts there and addicts here.

Regarding the organization of delivery of medical service, a British physician pointed out:

There are vast differences between London and New York, and I

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<sup>57</sup> Interview with Dr. Bewley, *supra* note 45.

do not think that you can import our method of treatment successfully. It is not important whether or not a clinic prescribes heroin or methadone or nothing. What is important is our national health system. You must remember that what we do for our addicts is always within the context of that national health system. Addicts, like all other Englishmen, expect and receive total health care.<sup>58</sup>

He also noted that British doctors are not paid according to the number of visits made or patients seen, but rather on the basis of the population in the area for which they are responsible. Therefore, a doctor's conscientiousness depends solely on his sense of responsibility, and most British doctors are highly responsible.

Regarding differences between U.S. and British addicts, this doctor said, "Most people in England have tiny habits and they are content to get by on a small habit."<sup>59</sup> When they are on prescribed narcotics, they settle down after a while and do not expect the "rush" and the euphoria. All they want from their medication is to stave off the pain of withdrawal. They supplement their prescribed heroin with barbiturates and amphetamines rather than escalating the heroin dosage. It is for these reasons that the withdrawal symptoms seem far less severe in England than elsewhere.

In describing the reasons why treatment is as innovative and individualized in England as it is, Peter Beedle, Assistant Secretary, Probation and After Care Department, Home Office said, "Nobody's head is about to roll, so we have flexibility . . . . The public does not require an accounting from the medical profession as to how money is spent on treatment of addicts."<sup>60</sup> This is because such treatment is part of the total national health program. Within this context, treatment of addicts and drug abusers in Great Britain makes use of a very broad spectrum of modalities. To a large extent treatment is tailor-made to fit the needs of each patient, and patients move from one modality to another with ease and no red tape.

The spectrum of services provided by the voluntary sector includes a day-care center for people abusing drugs and not yet in treatment; and half-way houses for people who are drug-free but not yet settled in their functioning and who either have no families or whose family situations are stressful.

For instance, the Community Drug Project, located in a rundown building in a working class section of London, offers drug abusers

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<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> Interview with Peter Beedle, *supra* note 47.

and addicts a physical place to "come in out of the rain" and supportive relationships with staff and other addicts, in the hope of moving people out of the drug scene.<sup>61</sup> The people the center services are similar, in life style and physical condition, to those referred to, in New York City, as "Bowery bums." Most started their drug careers on injectable Ritalin, and all have histories of severe emotional, although not necessarily financial, deprivation, which include early difficulties with the law, broken or neglectful homes, and being raised in foster homes and institutions. Activities like crafts and field trips are offered in the hope of awakening interest, lunch is sold, and help is given in obtaining medical care. The most important function of the center appeared to be the opportunity it offers for some minimal, beginning human contact to people who had been isolated and considered themselves beyond the pale. There appeared to be trust between patients and staff, and an honesty which the Director felt was not possible between a patient and the clinic which dispensed his drugs, because of the constant bargaining and mutual "collusive" manipulation with which the prescribing process is fraught. The furnishings and decorations of the center were made by its participants, and the place is seen as theirs and not as a charity. Of the 150 patients on the active list, 28 are now drug-free. Of these, 16 are still in rehabilitation programs and 12 are functioning completely independently in the community. This is a success rate of 8 percent, with a patient group who might easily have been seen as hopeless.

Another supportive service is Elizabeth House, a residential center or half-way house for 15 people, aged 18-30, of whom 10 are ex-addicts and 5 are non-addicts. Some of the ex-addicts have financially comfortable families in which there is emotional friction. Others have no home and were abandoned as children. Residents are expected to remain drug-free except for prescribed and carefully controlled sleeping pills and tranquilizers and to stay no longer than one year to avoid the tendency to institutionalism and its dependency, but when they leave they can continue to use Elizabeth House as a club or social center.

Helping these ex-addicts find and hold jobs is difficult. One of their big problems is their reluctance to face the new day, and consequent tendency to stay up very late at night and sleep all morning; and some employers are reluctant to hire them because they consider

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<sup>61</sup> The Center, in operation since 1968, has two trained social workers and three non-professional workers on the staff, and these are often the only non-drug users with whom an addict has contact, aside from his physician and his chemist. 55 to 60 people spend at least three days a week in the center and there are 150 people on the active list, 100 of whom have been active for four years.

them unreliable. These difficulties are somewhat offset by England's tradition of assisting the handicapped and its perception of addicts as handicapped.<sup>62</sup>

Despite these problems, one clinic reported that 50 per cent of their patients work full time. Many can work very effectively and successfully at highly skilled jobs, such as research chemist, technological inventor, or manager of a record company, while on narcotic medication.<sup>63</sup> Often, the employer does not know their medical background. Volunteers help find employment, and serve as "big brothers." Patients can also be referred to the Disabled Persons Resettlement Service of the Department of Employment, which provides special training, if needed, and finds employment. Additionally, those with records of criminal convictions are under the jurisdiction of the Probation Department, which also assists in finding employment and helping the patient maintain his work habits.

The British consider that more services are still needed. More half-way houses or hostels, and some which accept patients who are socially rehabilitated but on narcotic medication, are required. The Home Office is urging voluntary agencies to provide these for alcoholics and gamblers, as well as for addicts.

There is a need for follow-up social services for addicts detoxified in jail or hospital, to help them maintain themselves drug-free. Follow-up care is provided by clinics, so that new relationships must be developed and drugs may be prescribed too readily during this period of transition.

#### D. Education.

Drug education is woven into a comprehensive program of health care and of health education, and information about drugs is included with that on biological reproduction, venereal disease, and general hygiene, which are, in turn, part of science education. Additionally, much education geared at informing about drugs and thereby preventing experimentation with them is done informally by youth clubs, youth leaders, and classroom teachers who have a close relationship with the students. The British consider this much more valuable than lectures by drug experts who have no relationship with the students. Teachers and youth leaders inform themselves about the culture of the drug scene and about the effects of various drugs,

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<sup>62</sup> Interviews with C. Breckenridge, Director, Elizabeth House, and P. H. Connell, M.D.

<sup>63</sup> Interview with Leo Kelly, Nurse-in-Charge, St. Mary's Hospital Drug Dependency Center.

and use this knowledge, when appropriate, as part of daily life. No specialty is involved, nor even any special mandatory training, although teachers and youth leaders can be tutored by drug experts, and those who choose to take this training integrate this information into their general programs.

The attitudes of headmasters vary, some tending to deny the existence of experimentation among their own pupils, and others acknowledging the problem and questioning the role the school may be playing in contributing to its children's interest in drugs.

#### E. Comments.

The thrust of the British effort was, first, to contain the number of addicts by checking the spread of addiction; second, to prevent the growth of a black market and the crime that goes along with the need to meet black market prices; third, to rehabilitate those addicts who were not functioning well socially; and, fourth, as younger people became addicted, to wean addicts from drugs.

Certainly, they have stabilized the number of British addicts from 1969 on, and, certainly, the success rate of 60 percent functioning socially (40 percent with drugs and 20 percent drug-free) should be considered high, especially in light of the fact that many of the remaining 40 percent, those for whom nothing can be done except medical maintenance, have been addicted to narcotics for many years.

Those factors which contribute to England's success include:

1. Formulation of a clear policy on drugs as soon as addiction began to spread and before any action was initiated.
2. The existence of a National Health System which was available when needed to provide care for addicts, in existing facilities and with a staff already trained in treatment of alcoholism or related problems.
3. The support and cooperation of the medical profession in exercising more caution in prescribing dangerous drugs and in policing itself.
4. The cooperation of pharmaceutical manufacturers in limiting distribution of certain drugs.
5. Cooperation of the voluntary philanthropic agencies in providing supportive services.
6. Highly individualized and long-term comprehensive care, and provision of services to assist in all aspects of the addict's life, including housing, employment and counseling. Medical treatment, of course, is viewed as life-long, and social support and contact as long-term, when necessary. Addicts do not "get lost" in Great Britain. The

number of addicts is small enough and the staff of rehabilitation centers familiar enough with the drug scene so that if someone unexpectedly stops coming to the clinic, he is either located in the drug scene and contacted, or it is known that he has decided to "go it alone" without drugs.

7. Relative tolerance of the addict by the general population and the ability of the ex-addict or the functioning addict to melt back into the general community. In Great Britain, there does not exist the bitterness toward an addict which has arisen in the States because of the loss of property occasioned by thefts addicts commit to acquire money for drugs. Also, since nearly all addicts are white and British, their social ostracism is not complicated by "we-they" group distinctions.

It is still too soon to gauge what will be the effect of the year-old policy of tightening up on amount of drugs prescribed, greater insistence on substitution of methadone for heroin, and stronger attempts to move addicts away from drugs altogether.

### *Sweden*

#### A. History and Characteristics of the Drug Abuse Problem.

For the past 20 years, there has been a substantial amount of amphetamine dependence in Sweden. Some abusers swallow or inject such excessive amounts of the drug that the symptoms of their overdose (extreme agitation and anguish, motor excitation, random plucking movements, and twitching) require hospitalization.

In 1938, benzedrine, an amphetamine, was introduced into Sweden and widely advertised as a "pep pill." Although placed on prescription the following year, the drug became popular. By 1942, the Swedes estimated that 200,000 people (3 percent of the adult population) used amphetamines with varying frequency and 3000 were chronic abusers (at least 5-10 pills daily). Some injected as many as 50-200 tablets a day, leading to acute intoxication and severe personality changes.

In 1944, amphetamines were included among the narcotic drugs regulated by the National Narcotic Act. Most socially conforming people were deterred, and amphetamine abuse became concentrated in the "demi-monde" of petty criminals. To serve them, a black market in smuggled stimulants flourished. Injectable methamphetamine ("speed"), introduced about 1945, quickly became their drug of choice, and crimes of violence associated with its use increased sharply.

By the mid 1950's, phenmetrazine (Preludin) and methylphenidate

(Ritalin), amphetamine-like compounds, were also widely abused, and in 1959 they, too, were included in drugs regulated by the National Narcotic Act. In 1960, the National Medical Board circulated to physicians information on the dangers of abuse, and prescriptions were reduced by 40 percent. However, illicit manufacturing began, smuggling increased, drug charge arrests rose steadily (from 84 in 1963 to 540 in 1967), and by 1967 chronic abusers of amphetamines had risen to an estimated 5000.

In February, 1967, the newly formed Narcotic Drugs Committee recommended, for the first time, that therapy be provided for people who had become dependent on amphetamines. They opposed the building of special treatment facilities, urging the absorption of drug abusers into existing psychiatric facilities. In June, 1967, the Committee, in its second report, recommended more stringent penalties for smuggling and sales, and Parliament raised the maximum penalty for a drug offense from two to four years.<sup>64</sup>

By the following year, 1968, drug offense arrests had leaped to 1431, and 20 percent of prison inmates were abusers (mostly of amphetamine), so penalties were again raised — this time to a maximum of 6 years — and the government allocated two million crowns (\$400,000) to youth groups to run preventive programs.

The epidemic escalated, with 10,000 chronic abusers by 1969,<sup>65</sup> and a debate ensued over how to check it. There was substantial pressure for stiffer penalties and expanded police powers from various groups, one of which was the Swedish Temperance Movement, whose credentials as a progressive force dated from its campaign to end the practice of paying Swedish workers "in kind," with alcohol instead of with wages. There was an equally widespread cry that law enforcement was not the means to eradicate the problem, but rather that underlying social problems contributing to drug abuse had to be solved. The debate continues, but the prevalent view among government officials has been the latter.

The final report of the Narcotic Drugs Committee, in December, 1960, reflected this debate and stressed that drug abuse was a medical and a social problem whose solution required the coordination of both

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<sup>64</sup> According to the Office of the Public Prosecutor, central nervous system stimulants smuggled into Sweden now are generally manufactured (licitly and illicitly) in Italy, transported to Germany, Belgium, the Netherlands, and thence to Sweden. The largest recent seizure was of 20 kilos of phenmetrazine (Preludin). Current cost on the illicit market of 200 milligrams (usually 10 pills) of a stimulant drug is 30-50 crowns (\$6.00-\$10.00). Similar pills cost \$0.50 to \$1.00 apiece on the New York City illicit market.

<sup>65</sup> Estimate of the Narcotic Drugs Committee.

medical and social resources. The Committee also recommended that it be replaced by a standing advisory group, and such a group was appointed in March, 1970.<sup>66</sup>

Since then, with drug abuse services in hospitals operating, the public more aware of the problem, and the penalties higher, the extent of amphetamine abuse has leveled off.<sup>67</sup> However, morphine base began to be used in the autumn of 1971, and its use is increasing. In Sweden, the profile of the amphetamine abuser as described by the Swedish authorities, was, and remains, a person in his twenties and thirties (average age: 20-25), generally from a background of poverty and overcrowded living, often from a broken home, and given to aggressive and acting-out behavior. Morphine base users, in contrast, are younger (mostly 17-18 years but some as young as 12), with generally more contemplative, introspective personalities, from families which are financially sound but emotionally disorganized.<sup>68</sup>

Methadone has also appeared on the drug scene, and the National Board of Health and Welfare was, in June, 1972, formulating regulations controlling its dispensing, to prevent diversion. There is also developing a troubling correlation between marijuana use and abuse of alcohol, particularly strong beer, by youngsters in their early teens;<sup>69</sup> and an increase in barbiturate abuse.

## B. Social Causes of Drug Abuse.

Many Swedish officials stress social problems new to Sweden since World War II as a cause of drug addiction.<sup>70</sup>

World War II found Sweden a country with widely diffused small industries. After the war, Swedish industry, with government support, began to compete with the centralized industry of other European countries. Larger firms took over smaller ones and concentrated in the urban centers. People who had always lived with large extended

<sup>66</sup> Members include the heads of the Police Department, the Ministry of Health and Social Affairs, the Department of Education, the Chief Prosecutor and others.

<sup>67</sup> By May 30, 1972, there were 1200 addicts imprisoned (1000 in 1968). Jan Ording, of the Board of Health and Welfare, estimated in 1972 there were 5000 drug abusers in Stockholm, 2000 in Gothenberg, and 1000 in Malmo. Outside of the cities, drug abuse is negligible.

<sup>68</sup> There were ten prosecutions of sellers of morphine base in 1971 and Mr. Ording estimates there are 500-1000 morphine base users in Stockholm—up from 50 in 1970.

<sup>69</sup> In 1972 there were 100,000 alcoholics (estimated). Alcoholics in Sweden have long been treated in specialized locked centers. Diagnosis is made by a physician and can be contested in court.

<sup>70</sup> Interviews with Jan Carlsson, Secretary to the Prime Minister, Jan Ording, Assistant Director, Division of Social Care of Alcoholics and Drug Addicts, and Lars Berg, Director, Gula Paviljongen.



families on the farms and in the villages of Northern Sweden emigrated alone to the cities where they were housed in bedroom suburbs (one million apartments were built in the past 10 years) which lacked provisions for the cultural and social resources necessary to make them viable communities. There is little sense of "neighborhood" or of responsibility and concern for one's neighbors. People feel dislocated and isolated; permissiveness becomes not caring; liberalism becomes indifference. Some expressed the opinion that this move for economic competitive efficiency occurred too quickly, and that, in Lars Berg's words, "Sweden could handle problems of economic inefficiency much more easily than the problems of displacement with which we are now faced."<sup>71</sup>

This social disruption is reflected in a somewhat alarming increase in violence, and a smaller increase in petty theft, housebreaking, and forgery, none of which is particularly related to drug abuse.

There is some attempt now to compensate for the alienation of newcomers to Stockholm through communes and other cooperative living arrangements.

### C. Law Enforcement.

Drug law enforcement relies heavily on detective work to provide evidence of drug trafficking, rather than on informing or undercover agents. As the Swedish public is antipathetic to the use of undercover agents, deeming this to be entrapment and disruptive behavior, the police use none. Wiretapping is limited to cases of suspected murder or espionage and large-scale sale of drugs, and information so gathered cannot be presented as evidence. Informers are all volunteers who are paid only token amounts for their trouble. Their information is used to enhance detective work, such as surveillance. The Swedish police have the duty to *stop* someone from doing a criminal act, if they can, and therefore do not use informers to "lead to" a suspect.

Generally, the police arrest only on suspicion of sale, rather than simple use. There is no plea bargaining and cases are not prosecuted without substantial evidence. Therefore, the conviction rate is 80-90 percent. The degree of culpability charged does not depend solely upon the amount of drugs found in the suspect's possession but is related to other evidence uncovered. There are three penalties provided by law, each with a minimum and maximum, and it is in the discretion of the court to set a penalty based on all circumstances of the case.

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<sup>71</sup> Interview with Lars Berg, Director, Gula Pavilliongen, *supra* note 70.

Children under 16 apprehended for drug selling are turned over to the Board of Welfare, which has the power (largely unused) to institutionalize them mandatorily. The reform schools generally accept only children who voluntarily agree to be placed. Some police are specifically trained to deal with social problems of young people and handle minor infractions by discussions with them and their families.<sup>72</sup>

The police may hold an adult suspect for questioning for 12 hours before turning him over to the prosecutor, who, in turn, can hold him 5 days for investigation. If the prosecutor wishes him held longer, he must ask the court to place the suspect in custody, and the court has four days in which to decide whether to do so or to release him pending completion of the trial. There is no bail system. No witness can be held in custody before trial; however, if, during trial, one refuses to testify he can be held until he corrects his error, for a maximum of three months. The defendant may choose his own counsel. In more serious cases the state pays counsel fees, and in the case of minor charges, if the defendant is convicted he is expected to repay the attorney's costs to the state "if he has the money."

The administration of justice operates on three levels of authority: the district level, with 90 offices of prosecution; the county level (20 counties); and the national office headed by the Prosecutor General. All cases start in a district court,<sup>73</sup> and decisions may be appealed by either party with the permission of the Appeals Court. Appeals by the prosecutor to the Supreme Court are by permission of the Prosecutor-General.

Upon conviction, a user who is not a dealer may be sentenced to probation, conditional upon regular attendance at a clinic. Theoretically, he is subject to imprisonment, after a hearing, if he fails to meet the condition; however, the clinics are not obligated to report to the court on progress of a probationer nor even on whether or not he continues in treatment. A defendant may also receive an indeterminate sentence in a psychiatric hospital. Swedish courts use this provision only to order two to three days' hospitalization for detoxification.

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<sup>72</sup> Swedish police were recently nationalized and mechanized, and now patrol in cars and use walkie-talkies, but the Swedes plan to reverse this policy and return the officer to walking a beat in the hope that this will rebuild better relations with residents. Police carry guns, but are allowed to use them only in defense of their own lives. Crimes of violence against police, as against others, are increasing. Some police personnel, disenchanted with the job, are retiring to the country and recruitment of replacements is a problem.

<sup>73</sup> The district bench consists of one appointed judge and five laymen elected by the citizens of that district. Decision is by majority and the bench also sets the penalty. The Appeals Court bench is four appointed judges and they take testimony and review evidence. The Supreme Court sits with five judges.

Recently, maximum penalties were again raised, from 6 years to 10 years, but such a penalty can be imposed only with corroborative evidence of organized commercial trafficking, independent of the amount of drug found in possession. The basic reason for raising penalties was to keep the Swedish penal structure in line with that of the rest of Europe, lest Sweden become a center of drug traffic and a haven for traffickers.<sup>74</sup>

Swedish officials are also concerned with what they consider a lack of adequate cooperation on the part of other countries in the effort to prevent smuggling of amphetamines into Sweden.<sup>75</sup>

In addition to raising maximum penalties, Parliament, in 1972, tightened the rules relating to home leave from prison and provided more stringent regulation of parole procedure. Both these measures were aimed at the commercial trafficker. Since he is an experienced criminal, he knows how to behave acceptably in prison and therefore is often allowed home leave early in his term of imprisonment, and paroled after serving half his term. This militates against the goal of keeping the dealer out of circulation long enough to disrupt his operation. The new provisions were enacted reluctantly since they run counter to the widely shared Swedish conviction that incarceration of criminals generally should be short, as should hospitalization for drug use, and that both should be followed by rehabilitation in the community.<sup>76</sup>

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<sup>74</sup> Interviews with Astrid Kristensson, Chairperson of Parliament's Standing Committee on Justice, who sponsored the legislation, and Helgar Romander, Chief Public Prosecutor.

<sup>75</sup> The case of the elusive Mr. Pausch, believed to be the major smuggler of amphetamines into Sweden, illustrates this problem, as of June, 1972. Pausch, a national of the Federal Republic of Germany, was believed to be in either the Netherlands or his homeland. If arrested in the Netherlands, he would not be extradited, because the Dutch will not extradite a suspect, even the national of another country, unless the crime charged carries at least a one-year minimum under Dutch law, which amphetamine dealing did not. He could, of course, be tried there, but even if convicted would be out of circulation for only a few months. If arrested in West Germany, Pausch would not be extradited because under an agreement among the European nations, one cannot be extradited from one's homeland, although one may be prosecuted there for the crime charged in another country, using the evidence obtained by that country. Either way, the Swedes could not touch him. The Scandinavian countries (Norway, Sweden, Denmark, Iceland and Finland) have their own reciprocal agreement whereby a national of country A, convicted in country B, can be returned to his homeland to serve the sentence imposed by the country in which he was convicted.

<sup>76</sup> Ms. Kristensson emphasized that she reluctantly sponsored the bill raising maximum penalties because she is convinced that rehabilitation, even for organized commercial operators, takes place *after* imprisonment. "We have always believed jail is not good for people," she said, indicating imprisonment should be for a short time, followed by supervision in the community. She also urges that drug users be hospitalized for a short detoxification period and then assigned to professional social workers, "contact people," in their own community. Mr. Romander commented, of addict criminals, "it is good to

#### D. Treatment.

In the spring of 1972, Parliament anticipated that the spending priorities soon to be recommended to it by the National Board of Health and Welfare would reflect the need for field social workers, half-way houses, and other rehabilitative efforts outside of institutions.

The Board, which sets guidelines, agreed that hospitalization should be short and that half-way houses where drug abusers can stay after hospitalization or prison for as long as five or six years are needed.<sup>77</sup> However, convinced that drug abuse is a symptom of a broader social problem, they are hesitant to build a structure geared to treatment of a symptom, especially since there is widespread uncertainty as to how best to treat that symptom. The county councils, in turn, hesitate to put their money into uncertain projects.

Meanwhile, drug abusers are treated primarily in six state hospital wards in Stockholm, and one each in Uppsala, Lange, and Gothenberg.<sup>78</sup> Referrals are usually by the patient himself, his family, or a social worker, often a school social worker; sometimes of course, by the court. The government provides an income to each person during an illness, the amount, above a minimum, based on prior earnings. Hospitalization is free. All treatment is voluntary and most patients stay only one month, although, in the absence of half-way houses, therapists would prefer that patients remain in the hospital longer because recidivism occurs in inverse ratio to the length of supervision.

Many amphetamine abusers come from families with an alcoholic parent and many abused alcohol themselves first and then moved on to amphetamines. Dr. Siksna of Ralambshofs Hospital pointed out that drug abuse is more rebellious an act than is abuse of alcohol, because it is less socially accepted. Therefore, when amphetamine and barbiturate users revert to alcohol upon completion of treatment (as many do) this is viewed as an improvement because they are then reintegrated into the mores of the mainstream.

Some hospital wards commingle alcoholics and drug abusers, but many do not because drug abusers are far more manipulative and far

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take an addict away from drugs for a short while, but then, of course, you must treat him in the community where he must voluntarily stay away from drugs." Interviews, *supra* note 74.

<sup>77</sup> Interviews with Jan Ording, Board of Health and Welfare, and Carl Edvard W. Sturkell, Ministry of Health and Social Affairs. There are 40-50 long-term half-way houses, most in the North. Based on the number of patients in the hospital wards, the shortness of hospital stays and the desirability of long-term residence in half-way houses, it is estimated that 280 such houses are needed.

<sup>78</sup> General medical care is the responsibility of the counties, but the state governments provide hospitals with specialized services.

more demanding of staff time and effort than are alcoholics, thereby tending to monopolize staff. Morphine base and amphetamine abusers are commingled. Barbiturate abusers prefer to be treated in general hospitals, rather than in drug abuse services, because they are not in the same sub-culture as the amphetamine abusers. Morphine base users are more difficult to treat than amphetamine abusers, perhaps because they are younger (17-18 years) and therefore their personalities have been less stabilized before the onset of drug use than have those of the (older) amphetamine abusers. They need habilitation, not rehabilitation.

Social therapy for drug abusers concentrates on helping them achieve gratifications from means other than drugs. Group and "milieu" therapy are the primary treatment modalities. Patients' friends or spouses are allowed to live in the hospital with them. Hospitals vary in the extent to which they involve the parents and families of patients in working out family problems. Families have often "washed their hands" of their offspring by the time they reach the hospital. Staff does attempt to follow up with patients after medical discharge but maintains no contact with those who drop out.

Chemical therapy includes methadone for some morphine base users and chlorpromazine for the treatment of acute symptoms of amphetamine abuse. Methadone is considered effective only if tied to close follow-up and frequent contact between patient and physician. In June, 1972, pending national guidelines, it was being used for short-term treatment to prevent withdrawal while a patient is awaiting hospitalization, and in a very limited way as a maintenance program.<sup>79</sup>

An essential part of the rehabilitation effort is the ultimate employment of the rehabilitated drug user. This is a problem. There is now a 2 percent unemployment rate in Sweden, although menial jobs traditionally left to other nationality groups, such as Finns, Yugoslavs, and Turks, are available. Although this rate is low by U.S. standards, it is high for Sweden, and those unemployed are young people just entering the job market and persons over age 64. There are currently 110,000 people in job retraining programs. The drug abuser's rehabilitation is complicated by this job shortage and further by the fact that the civil service will not hire ex-convicts. His employability is also frequently handicapped by alcoholism.

An outpatient self-help group, the National Organization for the

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<sup>79</sup> Seen as a last resort modality, methadone maintenance is prescribed only for a patient at least 22 years old, who has been addicted for at least 3 years and has been involved in criminality.

Help of Addicts and Drug Abusers (RFHL),<sup>80</sup> concentrates on the theory that increasing one's self respect diminishes one's need for drugs. They encourage people to contribute socially useful service despite occasional drug binges or even while they are regularly on drugs. The goal is to shorten the binges and lengthen the time between them until the need for them completely disappears.

One residential treatment center for 18 boys and girls aged 16 to 20 who are in trouble with the law is the Gula Paviljongen. The youths are referred there by the courts or the Board of Health and Welfare. Most are involved with drugs, though their difficulties with the law are not necessarily related to drug use. This center accepts only volunteers, and allows them to stay for a maximum of eight months, although a resident may apply for readmission at the end of that period. "Institutionalizing" by long residence is avoided.

Most of the residents come from homes replete with tensions and failure of communication, many from foster homes or orphan homes. Lars Berg, Director, described them as generally dependent and immature, with a tendency to lean on staff to make decisions for them, and with many problems about how to form relationships. Here, residents learn to cope constructively and each is encouraged to make his own decisions on matters affecting him. For each group of seven there are four staff members (one a social worker) who work in shifts, so there is always an empathetic ear available. Human relationships are intense, and each entering group spends its first week camping together on an island, to accelerate the formation of close relationships.

They must work from 8 a.m. to 5 p.m., and must attend group therapy sessions three times a week. No drugs at all (including alcohol) are allowed. Work is done on the premises — primarily carpentry and gardening.

The Board of Health and Welfare helps each graduate seek an apartment and a job and Gula Paviljongen staff stands behind him, but refuses to take over for him. Often there are difficulties. Employers are reluctant to hire them, expecting emotional instability. Half-way houses would allow graduates to function independently while giving each other emotional support and having the help of skilled staff.

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<sup>80</sup> The group, formed in 1965, is a cooperative endeavor by the trade union of hospital workers, an organization of ex-psychiatric patients and present and ex-drug abusers and addicts. They lobby for legislative and administrative change and offer group therapy and individual help to addicts and drug abusers. They operate with public and private funding.

### E. Prevention and Education.

In 1968, the press launched a "scare" campaign. This had a negative effect. It glamorized drugs and made them appealing to those with self-destructive tendencies.

Since February, 1969, anti-drug education has been administered mainly by youth groups. Traditionally, these groups, such as the youth divisions of political parties, churches, and service groups like the YMCA and YWCA are very strong and very active and many have existed for quite some time.

Prevention is also the job of "search out" teams of social workers who mix with young people and attempt to help them. Additionally, prevention is viewed as early identification of a family's social problems, *e.g.*, through interviewing all families who come to well-baby health clinics. Even more broadly, it is viewed as the resolution of broad social issues requiring political decisions such as city planning and joining the Common Market (as connected with centralization of industry and consequent urbanization).

### F. Comments.

Swedish authorities do not view drug abuse as a direct cause of deviant behavior or crime, except for the temporary mental aberrations induced by amphetamine overdose and the violence associated with the use of methamphetamine. They believe that those who commit crimes and also use drugs would have committed the crimes without drugs. Their concern about drugs flows from their exceedingly high expectations of the capacity of their government and social system to ensure near-universal personal productivity and mental health.

Since, in their view, drug abuse is a symptom of more basic social problems, it stands as a reminder that many of these problems remain to be solved.<sup>81</sup> Sweden is now in the process of grappling with them and is evaluating and reviewing how certain programs have actually worked out. To reverse the intense urbanization, government agencies are slated to be decentralized, to enable civil servants presently concentrated in Stockholm to move to smaller cities and to permit people living in small villages to find government employment.

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<sup>81</sup> Sweden has been, historically, singularly free from conflicts and struggles. It was never occupied by a foreign nation. It is rich in natural resources. It has little history of internal class struggle. There was never a feudal system in Sweden. Each peasant owned and worked his own farm, in addition to working the large estates. In light of this history, Jan Carlsson, Secretary to the Prime Minister, commented, regarding the present urbanization and drug abuse crises, "We were a peasant country. Now 85% of us live in cities. We are bewildered."

Policy regarding the treatment of drug abuse is still experimental and there is a tentativeness in official tone. Local advisory groups complain they cannot obtain sure advice on treatment modalities, funds are not appropriated for certain services such as half-way houses because no firm decision has been reached regarding their probable effectiveness. The Standing Advisory Committee on Drug Abuse and the Board of Health and Welfare continue to clarify policy and to present recommendations to Parliament.

### *The Netherlands*

The Netherlands is of special interest because, despite the current popularity of hashish, a singularly small proportion of her population is interested in other drugs. Officials see no evidence that hashish smoking, in their country, leads to the abuse of other drugs and they do not anticipate an escalation in drug abuse. They view this use of cannabis resin by their young countrymen with concern, but not with alarm or excitement; they arrest traffickers, provide what treatment is needed, much of this for foreigners on their soil, and do not rank drug abuse as a major problem.

Officials comment, "We are not a drug-oriented people." There has never been a substantial number of alcohol abusers in the Netherlands.<sup>82</sup> There is also a relatively minor use of drugs for medical purposes<sup>83</sup> although this is left to the discretion of the medical profession, and there are literally relatively few pharmacies in Holland.

In the latter half of the 1960's, there began to be some abuse of amphetamines, LSD, and opiates other than heroin. In 1967-1968, the police responded with a flurry of arrests of users. This policy was quickly dropped and law enforcement concentrated on trafficking. In 1968 there was a brief wave of popularity of injectable methamphetamine (speed), accompanied by an increase in car thefts and other property crimes, and, according to the police, by violence.

At present, aside from the small group of elderly Chinese opium smokers (a group which is left in peace in the Netherlands, as elsewhere), what drug abuse there is occurs mainly among middle class

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<sup>82</sup> Interview with Hon. W. B. Gerritsen, M.D., Director-General of Public Health. There was some alcoholism at the end of the 19th century among poorer working people, which was virtually eradicated through the efforts of trade unions and voluntary agencies. Recently, there has been a slight increase in alcoholism, this time among all strata of society, but alcohol consumption in the Netherlands remains one of the lowest in Europe.

<sup>83</sup> Amphetamines, for instance, although labelled as effective in weight reduction and in treatment of narcolepsy, are not usually prescribed as anti-depressants or agitation relievers. The Dutch do not recognize "hyperkinesis" as a diagnosis and therefore do not prescribe amphetamines to hyperactive brain-injured children.



15-25 year olds, students and non-students, and is associated with anti-establishment attitudes. Hashish is the only drug they use regularly, but there has been a growing amount of one-time, curiosity-satisfying experimentation with other drugs,<sup>84</sup> most often one of the amphetamines. All told, authorities estimate there are about 2000 people on Dutch soil involved to some extent in drug abuse, many of them foreigners.<sup>85</sup>

The Dutch are concerned with the "drifting away" or drop-out syndrome often connected with the use of hashish (a 1971 survey showed a higher drop-out rate among drug users than non-users, but not a causal relationship between drugs and dropping out). Its chronic use seems to result in a lowering of academic performance and therefore, in their view, causes social harm. For this reason alone they prefer not to legalize cannabis. Beyond that, there is a wide divergence of opinion about the degree of its dangerousness, and it is the one drug about which there is some emotional and political reaction. One political party, the *Kaboutors*, made a major issue of its campaign for government regulation and control of the supply of cannabis. The prevailing attitude is watchful concerned tolerance. The government encourages the provision of youth centers in which hashish smoking is tolerated; poetry reading, jazz concerts, and films are sponsored; and various kinds of adult help and guidance are available, on the theory that if young people are going to smoke hashish, it is best to contain this recreation to a place which is adult-supervised.<sup>86</sup>

#### A. Prevention.

To implement all aspects of administration dealing with drugs, including prevention which has top priority, there is a coordinating committee with representatives of the Ministries of Health, of Culture, Recreation and Welfare, and of Justice. Delivery of most services, even probation service, is by a private agency, subsidized by the govern-

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<sup>84</sup> A 1971 survey by Backhausen of 15-18 year olds revealed that 19% had smoked hashish at least once, 14.7% had experimented with an amphetamine, and 11% with LSD.

<sup>85</sup> Only one-quarter of those arrested on drug-selling charges in 1971 were Dutch nationals. Almost all opiate addicts in treatment at *Jellinek Klinik* are foreigners.

<sup>86</sup> The *Clubs Paradiso* and *Cosmos* are two examples. They are frequented, along with young Dutchmen, by the backpacking, often moneyless, international travelers who flood the capitol each summer, sleep in *Vondel Park*, and cluster around the city's fountains. Since the regular tourist trade is important to Amsterdam, the city tries to keep this group out of their way. Certain spots, such as *Vondel Park*, are theirs. The government provides mobile sanitary facilities, medical care, emergency food and information on inexpensive housing. Antagonism to these visitors is not widespread beyond complaints that the park is crowded, but their care is a substantial expense.

ment.<sup>87</sup> Preventive programs are delivered directly, both by public agencies and private ones.

The Dutch view drug abuse as a sign of failure of self-confidence and the best prevention to be the inculcation of same. Programs, therefore, emphasize the desirability of taking responsibility for oneself and reaching one's own informed decisions on all aspects of life, including drug use.<sup>88</sup>

There is a National Federation for the Education of Addicts, which has taken a great deal of responsibility for education about drugs. Drug education is included in schools' hygiene curriculum usually in the context of a discussion of other hygiene problems, and there is a cautiousness about the dangers of over-emphasizing drugs and thereby glamourizing them. Jellinek Klinik, which treats drug abusers, runs training programs for hygiene teachers, and also for army chaplains, clergy, and others.

## B. Drugs and Crime.

There is no known illegal drug manufacturing in Holland nor any diversion of drugs from medical channels. There is some amount of smuggling from Germany through the port of Amsterdam.<sup>89</sup> Organized crime is involved in smuggling *through* the Netherlands, but not in domestic traffic.

Government officials stated that although there had been a recent increase in crimes of violence in Holland, these were not connected with drug use. On the other hand, a prisoner interviewed at Amsterdam Detention Center No. 1, who had been arrested for smuggling hashish, said that the drug scene was hardening sharply. As he put it, "it used to be a friendly, easy scene, and people gave each other drugs for pleasure . . . . Criminal elements are moving into the scene and introducing violence. Suddenly there are knives and guns around . . . ."

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<sup>87</sup> The Hon. G. A. A. van Megen, of the Ministry of Culture, Recreation and Welfare, explained that his ministry, for instance, subsidized private psychotherapeutic agencies, as well as private adoption, foster care, and other social services.

<sup>88</sup> Hon. J. H. Grosheide, State Secretary, said the central short-term question in Holland is: Will it be possible to provide the public quickly with adequate information about drugs on which to base informed decisions? And Hon. P. Siderius, Secretary-General of the Ministry of Health said: "The Dutch approach [to drug abuse] is to convince people that using drugs does not solve the social problem about which one is concerned." One educational film aired on television and geared to teenagers emphasized that one must make many decisions in life for oneself and dramatized this with examples depicting situations where decisions were required about the use of alcohol, about socializing versus doing homework, about sex, and about drugs.

<sup>89</sup> Although Rotterdam is a larger port than Amsterdam it is singularly free of smuggling or other crime. It is seen by the Dutch as a "square" hardworking city.

A substantial proportion of those arrested on drug charges are visitors to the country, or recent immigrants.<sup>90</sup>

### C. Laws, Law Enforcement, and Confinement.

The Opiate Law of 1928 provides a maximum penalty for trafficking in opium and its derivatives of four years imprisonment and a \$900 fine. Amphetamines are controlled only by the laws and regulations governing general pharmacological trade, and the maximum penalty for trafficking illegally is three months and \$100 fine. Although the Dutch consider this adequate for their own purposes, they expect soon to raise the maximum to at least one year and to permit extradition, as a concession to foreign pressure. They plan no other changes in their penal law.

Dutch procedure upon arrest is as follows: When the charge is violation of the Opiate Law, the police can hold the suspect for questioning for two days and the prosecutor can for another two days. If the prosecutor wishes to hold for a longer period he must ask the court to issue an order to "hold under instruction," in which case the prisoner can be held indefinitely for investigation. It is also within the prosecutor's discretion to suspend prosecution on condition that the suspect accept hospitalization. Most of the foreign citizens arrested for drug trafficking have thus been held without trial for a few weeks and then expelled from the country.<sup>91</sup> The charge is determined by corroborative evidence (fingerprints, observing a sale) or a confession, rather than simply by the amount of drug found in possession.<sup>92</sup> Conviction leads to imprisonment, or a fine, or the judge may suspend sentence on condition the defendant obtain treatment.

Most of those prosecuted are sellers, but some are chronic users. The latter are usually fined, but alternatives include probation to follow hospitalization, or a suspended sentence (with or without a fine) on condition that the defendant be hospitalized and then attend a clinic. In such a case, the clinic submits progress reports to the court.

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<sup>90</sup> In 1971, according to the police, there were 880 arrests on charges connected with sales of hashish, LSD, and opiates. Of these, they said, 106 were U.S. citizens (the U.S. Embassy figure was 96), 150 were immigrants from Surinam, 250 were Dutch nationals, and the remainder were visitors from a variety of countries. At the time of this study, of those prisoners who were detained on drug charges, 30% were foreigners, primarily Italians, French, and Moroccans.

<sup>91</sup> When it is decided to prosecute a case under investigation, the court decides if the prisoner is to be released or detained pending completion of trial, and it is at this point, before that decision is made, that the prisoner first gets legal counsel. Trial is before a one or three-judge bench with no jury and the verdict may be appealed by either side.

<sup>92</sup> When such evidence is lacking, cases are not prosecuted and therefore there is a rate of conviction of almost 100% of cases prosecuted. Confessions are frequent. There is no protection against self-incrimination and the defendant may be required to testify.

When a suspect is arrested for possession of amphetamines without a prescription, the police can hold him for only six hours, no matter how large his cache, and then forward the case to the prosecutor, who investigates while the subject is at large.

Citizens in the Netherlands, unlike Japan, do not generally report to the police cases of suspected drug abuse or sales, although civil servants technically are required to do so. According to the Ministry of Health, the Dutch entertain a dislike for men in uniforms, and this includes their own police department.

A visit to Detention Center No. 1, Amsterdam, holding 150 men 23 years and older who are awaiting trial or who have been sentenced to a prison term of three months or less, revealed that 10 percent of the present inmates are drug users, one-fifth of them having been arrested for drug trafficking, the rest for crimes not related to drugs. There is a cultural clash between those in on drug charges, who are viewed as "hippies," and the "old guard" ordinary felons who see themselves as "honest thieves." Each prisoner has a private cell, individualistically decorated, and all cell doors are open during the day. There is a work program and a sports program. Staff includes the governor, a half-time psychiatrist, a male psychiatric nurse, a half-time physician, a clinical psychologist, several psychiatric caseworkers and guards.<sup>93</sup> Despite the presence of this professional staff and the individual attention and help given prisoners, the Dutch "make no pretense of providing 'treatment' in prison." It is their conviction that it is impossible to provide meaningful treatment inside a prison, that treatment must be part of a "total community effort," and that none should be sent to prison for the purpose of receiving treatment.<sup>94</sup> They do, of course, provide the required medical care for drug addicts, as for all prisoners.<sup>95</sup>

#### D. Treatment.

As in Sweden, the psychiatric hospitals are reluctant to absorb drug abusers into their general services because of their demands for an inordinate amount of staff time. Almost all treatment of drug abusers is done at Jellinek Klinik, an alcoholism clinic which, in

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<sup>93</sup> All medical professionals are assigned only half-time to a prison in order to ensure their continued practice in the "mainstream" of their profession and to avoid absorbing the doctor into the bureaucratic system.

<sup>94</sup> Interviews with H. H. Postma, Governor, Huis van Bewaring (Detention Center) No. 1 and N. W. de Smit, M.D., Consultant Psychiatrist, Ministry of Justice.

<sup>95</sup> Those who had been on methadone at Jellinek Klinik prior to imprisonment are continued on their medication. Those who require it are given methadone during detoxification.

the early 1960's, at the request of the court, agreed to accept drug abusers. Two-thirds of the 2500 patients are abusing alcohol, many in conjunction with amphetamines. Eight to nine hundred of the patients are adolescents.

The clinic staff works in teams, each team including a physician, two psychiatrists, a social worker and a nurse, and they attempt to give "total help," by which they mean help in all aspects of the patient's life situation. Intake is done immediately when an applicant walks in off the street and after further study, staff and patient decide on the treatment.<sup>96</sup> The clinic has 99 beds, used mostly for detoxification, and an annual budget of about five million guilders (\$1,500,000).

Emphasis in therapy is on "repairing the break between that person and others," said Mr. Krauweel, Director, and therefore staff intensively involves families of patients.<sup>97</sup> Families are offered psychotherapy, when appropriate, and emotional support in learning to cope more constructively. Patients participate in activities which encourage interaction among them. Mr. Krauweel is convinced that medication can be helpful only if it is dispensed in a setting small enough to allow staff to have an overview of what is happening in the patient's life and to intervene when appropriate.

An important part of therapy is helping each patient find a job he can handle — "some niche" in which he can earn a living. This takes imagination and exploration of jobs that do not require punching a time clock, and many ex-patients work in bookshops, record shops, and art shops, where they can keep irregular hours, since they are more comfortable with this life-style.

The clinic is also encouraging an organization called Drugs Anonymous, which is patterned after Alcoholics Anonymous.

#### E. Comments.

The Aldermen of the Amsterdam municipal government shared with the writers their view that the Netherlands has some social problems, the major one at present being a severe housing shortage in Amsterdam (there are 8000 houseboats on the canals of that city), that

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<sup>96</sup> Two hundred of the opiate addicts (average age, 19-20, and almost all foreigners) receive low dosage methadone (initial dose of 60-80 milligrams tapered down to 20 milligrams) to stave off withdrawal symptoms, and some are drug-free and maintaining themselves with the help of psychotherapy, offered by social workers or psychiatrists. Methadone is usually in fluid form, controlled under the Opiate Act and by the Department of Pharmacology.

<sup>97</sup> When a patient is hospitalized at the clinic, for instance, his family is urged to visit twice a day. Most of the patients have kept some ties with their families, even if only through an occasional visit home for a hot bath and a meal.

the abuse of drugs is a symptom of the pressures imposed by these problems and that something is being done about the problems. Having survived foreign invasions and continued encroachment by the sea, they appear calmly confident of solving present major problems and disinclined to get overly excited about lesser ones.

They further indicated that their traditional tolerance of behavior which was non-conforming to the majority mode was in itself a value they chose to cherish and perpetuate.

The authors found that not only in the Netherlands, but in each country studied, the approach to drugs is shaped by the specifics of that nation's drug problem, its total social situation, its goals, and the priorities it assigns to different values. Therefore, no program can be wholly transplanted. But whatever differences exist in the specifics of the anti-drug abuse efforts of each country, those which succeed all share the following: a clear goal and universal commitment to it; a social climate which permits a reformed addict to develop a productive life-style; a penal program which furthers the country's social purpose and which has community support; and coordination of all efforts, including community cooperation.

New York State's drug problem has two distinct components which do not exist in combination anywhere overseas: first is the sheer volume of its addicted and drug-dependent population (New York State, with 18 million inhabitants, has an estimated 200,000 addicts; Greater London, with a population of 9 million, has 2000); second is the long-term close connection between addiction and a criminal life-style which began with enforcement of the Harrison Act and flourished during the 50-year hiatus between then and the opening of adequate numbers of treatment centers.

The United States has its own unique characteristics, as does New York State. Most obvious is its very size, which hinders coordination and uniformity of effort. Second is the heterogeneity of its population, particularly in New York State, and the extent to which social organizations are based on ethnic groupings. Each emerging problem is overlaid on preexisting prejudices and recognition of solutions is clouded by "we-they" ways of thinking and fears of "the other" — *e.g.*, when a predominantly white community objects to a narcotic treatment center in its midst, is it afraid of addicts, of crime, or of Blacks? Also unique to the States, and particularly New York, is the extent of social and physical mobility of its population, which weakens the family and neighborhood structure which could otherwise oversee the continued conformity of the ex-addict. New York's drug problem is

superimposed on an underlying crisis of general failure of education and job training and housing, particularly in urban centers.

The Empire State, like this nation, also has special strengths, particularly our constitutional safeguards of equal protection of the law and our tradition of civil liberties, and we are unwilling to diminish these to accommodate to a particular problem.

Our own solutions to our drug problems are shaped against the background of these conditions and by these values.

#### NEW YORK STATE: THE PRESENT PICTURE: AN APPRAISAL

##### *Rehabilitation of Addicts*

At year's end, 1972, New York City's Health Services Administration claimed a total of 52,782 addicts in treatment, of whom 32,111 were in methadone maintenance programs (up from 4000 in 1970).<sup>98</sup> The remainder, many of whom are hospitalized briefly during detoxification, are in drug-free therapeutic communities and in "store-front" type programs which rely on emotional support and practical help from staff and from other participants to counteract the temptations of the street. Indicators hint that a turnabout in the hitherto steady growth of heroin addiction has begun. There has been a slight decrease in deaths from drug-overdose or drug-related infections (May-September, 1971: 480; same period, 1972: 358).

Additionally, the treatment programs, having existed long enough so that results can be assayed, and with increased experience in techniques, have begun to demonstrate a clear correlation between treatment and drop in arrest rate, borne out by a decrease in the reported number of those crimes typical of addicts.<sup>99</sup>

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<sup>98</sup> We have, of course, opted for methadone as the medication of choice, if any is required. Heroin maintenance in the 1920's might or might not have prevented crimes for money for drugs. Today, with many addicts making it in drug-free and methadone treatments, with allegedly non-addictive substitutes being researched, with an extended shortage of heroin in the streets and no discernible panic, and with the high dilution of what heroin is available, heroin maintenance would serve only to re-escalate an epidemic.

<sup>99</sup> Patients in methadone maintenance programs show a 96% decline in arrest after 13 months of treatment. Patients in drug-free treatment show a 68.5% decline in arrests after one year of treatment (77.5% for those in treatment more than three months, 66.8% for those in treatment less than three months). With many addicts, there is the question of which came first—drug abuse or crime? This is increasingly hard to ascertain as the average age of addicts drops. There are clues that many were into criminal activity before drugs. (A small-sample unpublished study by James F. Morgan, Jr., for instance, revealed that those studied who were in the 21-30-year-old group and who had criminal records prior to their addiction had committed twice as many felonies and three times as many non-narcotic misdemeanors prior to their addiction than they did after they became addicted). Therefore, the decline in arrest rate for those addicts in treatment suggests that the techniques used in drug rehabilitation aid the addict not only in his drug problem but also in the attitudes and reactions which may have led him into crime independent

With the emergence of a substantial body of reformed addicts, the issue of employment for them has become urgent. A 1972 study found that many face great difficulty in finding employment when they are ready for it.<sup>100</sup> In addition to whatever other job disabilities they suffer, such as inadequate schooling and an arrest record, they also face discrimination based solely on their past addiction or present status as methadone-maintained patients. This frustration of an ex-addict's drive to become self-supporting and socially constructive nullifies the whole rehabilitative effort. One hopeful sign is a beginning awareness on the part of segments of the business community that it makes very good business sense to hire rehabilitated addicts.

Another rehabilitation problem which is highlighted as more addicts graduate from treatment is New York's less than adequate provision of the personal, sometimes long-term, emotional support and practical help and supervision often necessary for their continued success, and the frequent absence of a "community" which has genuine concern for the graduate and makes room for him.

Those countries overseas most successful in helping their addicts regain self-respect and function socially do provide this individual care over extended periods — for example, Japan through its volunteer probation officers and England through its medical staff. People do not get lost in the shuffle.

Several recent U.S. studies indicate that here, too, continued supervision, when available, is helpful. One reported that those addicts who come to treatment via the court route, and are released under compulsory community supervision of a parole officer, do better in the long-term than those who are released without supervision.<sup>101</sup>

But in New York State, although state law provides that NACC can give after-care supervision, we still "lose" thousands. Voluntary treatment agencies admittedly make no effort to find patients who "split." There is no established community "buddy" system to smooth the re-entry of an ex-addict into the community and help him stabilize himself. The lines of communication between a treatment facility, the branch of the police department to which it reports an absconder, and the judge who sent the addict to the facility are frequently ruptured somewhere along the way. Joseph Dow reported in January, 1973, that

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of addiction. Rehabilitation of addicts could well lead to new techniques of rehabilitating offenders in general.

<sup>100</sup> *Employing the Rehabilitated Addict*, 1973 N.Y. LEG. DOC. No. 10 (1973).

<sup>101</sup> Vaillant, *A 20-Year Follow-up of New York Narcotic Addicts* (paper presented to the National Research Council, Ann Arbor, Mich., May 22, 1972).



“there are nearly 7000 addicts or former addicts legally under the care of the state’s Narcotic Addiction Control Commission that the Commission cannot locate.”<sup>102</sup>

It is true, of course, that it is far easier to drop from view in New York City, with our many scattered pockets of addict concentration and our plethora of rooming houses and transient hotels, than it is in London or Tokyo. Even so, there has been a failure of follow-up and of accountability.

### *Law Enforcement and the Judicial System*

Essential to the success of anti-drug-abuse enforcement is community support, and this requires perceived even-handed enforcement of the law at all levels of involvement in dangerous drugs, including manufacturers, distributors, dispensers, and consumers of legal drugs, and smugglers, dealers and consumers of illicit drugs,<sup>103</sup> as well as a penalty range which permits the court to take into account all pertinent facts in each case. Penalties must be seen as related to the degree of danger to society, to the profitability of the crime, and to the persistence of the offender. Also essential is a parole system which does not countermand judicial intent.

New York City law enforcement efforts have been hindered, until recently, by lack of community support, due partly to poor police-community rapport, partly to a fairly widespread impression that law enforcement has been “hard on users, soft on pushers,” and partly to the perceived inequities of the penalty structure, as well as to public awareness that the paucity of treatment facilities made it unlikely that reported addicts would be helped.

With regard to rapport, in neighborhoods with a high level of addiction, many have hesitated to call police attention to addicts but have reported suspected traffickers, and have found the police seemingly non-responsive. While there may be good reasons for this uncommunicativeness, it has not been conducive to good police-community relations. However, the recently initiated and highly visible outreach program of the police department, by which the police offer concrete help

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<sup>102</sup> N.Y. Post, Jan. 22, 1973, at 36. A NACC spokesman was reported in that article to have stated that “only” 35% of the absconders had been sent to the Commission after being found guilty of a crime.

<sup>103</sup> The cooperation of the Japanese citizen with the police in identifying drug abusers and addicts which so greatly enhanced law enforcement there was apparently based on public awareness of the thoroughness and simultaneousness of the police attack on smuggling rings along with their roundup of users, as well as on the conviction that an identified addict would be rehabilitated.

to addicts and are available on the street to talk to residents is an important step toward building better relations.

Police concentration on users and small peddlers may have been encouraged in New York City at one time by arrest quotas. Now, despite the setback of the terror raids by some federal agents in the Midwest, the credibility of federal and local law enforcement has been somewhat enhanced by recent well-publicized arrests of big dealers and smugglers.

The federal penalty structure was revised in 1970<sup>104</sup> to provide an A felony category, with its maximum life sentence, for major narcotic dealers; and dealing in bulk in non-contraband drugs has, as of September 1, 1973, become a felony under New York State law.<sup>105</sup> The State Controlled Substances Act now defines what is legal for all levels of non-contraband drug operations and, in line with federal law, defines contraband drugs.<sup>106</sup>

Along with these changes has come a change in the tone of those in communities most infected with drug abuse. People are increasingly tired of being "ripped off", they know rehabilitation is more available, and community attitude appears to be hardening into a determination to get rid of unreformed addicts and of pushers.

Premature parole in cases in which the court had not set a mandatory minimum but had relied upon the parole board to recognize that certain factors in a prisoner's case indicated he should remain imprisoned for several years, has been a problem. This should be diminished by the newly enacted mandatory minimum sentences for some drug crimes.

The impact of the penal law revisions enacted in 1973 will not be gauged for some months. The timing of the Act is unique, coming as it does at a time when the use of heroin, at least, has been declining for a year. Nevertheless, having enacted the law, any governmental ambivalence about its enforcement may be as counterproductive as implying that arrests alone will end drug abuse.

The legislature and executive have wrestled with how best to shape a penal program which is not only equitable but also allows for the rehabilitation of everyone who can be rehabilitated and the isolation of those who cannot.

To this end, certain clearly defined principles are relevant:

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<sup>104</sup> Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 841-51 (1970).

<sup>105</sup> N.Y. PENAL LAW § 220 (McKinney Supp. 1973).

<sup>106</sup> Ch. 878, [1972] N.Y. Laws 3296.

A. That the penalty structure differentiate among those convicted of varying degrees of culpability, particularly between those who traffic for profit and those who traffic incidental to their personal usage.

B. That commercial traffickers (1) be imprisoned for periods long enough so their incarceration disrupts illicit drug commerce, and (2) be more severely penalized with each arrest subsequent to the first.

C. That those convicted of possession or transfer of the smaller quantities (1) be given one chance to opt for treatment, and (2) that persistent offenders, having rejected their "one chance," be dealt with with extra severity.

Most important, perhaps, is that whatever specific form New York penal law takes, it must be clear that it will be enforced.

### *Coordination*

The multi-faceted attack against drug addiction launched by New York State in 1966 should involve almost all segments of society. The need for coordination of their efforts, on and between state and local levels, was recognized by New York State as early as 1966. However, it was seen as the responsibility of the Narcotic Addiction Control Commission,<sup>107</sup> rather than of a coordinating mechanism independent of any single operational agency, as in the United Kingdom, Japan, Sweden and the Netherlands. Coordination of law enforcement efforts on the federal, state and local levels is the responsibility of the Office of Drug Abuse Law Enforcement.

In the City of New York, the Mayor's Narcotic Council was established in 1970<sup>108</sup> but after a few enthusiastic sessions, attendance fell off and it became non-functioning. Its failure has been attributed to the fact that it was staffed by only one part-time worker; and to bureaucratic resistance, particularly by the Bureau of the Budget, to projects operated jointly by two or more agencies. Efforts are underway to reactivate it.

There remains, however, a need for inclusion of still more segments of society, notably, the judicial branch and the business com-

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<sup>107</sup> N.Y. MENTAL HYGIENE LAW § 81.09(b) (McKinney Supp. 1973) states:

With the advice of the council on drug addiction and with the assistance of any interdepartmental council or committee . . . charged with the responsibility for interdepartmental cooperation and program development in drug addiction, [to] promote, develop, establish, coordinate and conduct unified programs for education, prevention, diagnosis, treatment, aftercare, community referral, rehabilitation and control in the field of narcotic addiction, in cooperation with such other federal, state, local and private agencies as are necessary. . . .

<sup>108</sup> Members include the heads of the Human Resources and Health Services Administrations, the Police Department, the Corrections Commission, the Criminal Justice Coordinating Council, the Board of Education and the Vera Institute of Justice.

munity, in communication and coordination efforts, and for regularization of these efforts. A committee which encompasses government executive agencies, the courts and corrections, industry, community groups, which represents both the state level of supervision and the locality and which has liaison with the legislature should have regularly scheduled meetings attended by staff who have decision-making powers and are in a position to implement decisions, and should be itself adequately staffed. Such a group might or might not also serve as an advisory group on policy.

### *Multi-Drug Abuse and the Teenage Drug Culture*

Until very recently, attention has focused almost exclusively on rehabilitation of narcotic addicts and on the penalty structure for drug crimes, and New York has achieved notable progress in reversing the tide of narcotic addiction. However, researchers now find that many who are newly off heroin are "stoned" on other drugs. Except that these drugs are still cheaper than heroin, the social advance is negligible. We face two alarming developments. First, the escalation of multi-drug abuse (the use of different drugs, both contraband and non-contraband, in combination); and second, the emergence, during the latter half of the 1960's, of a subculture of teenage drug abusers quite separate from the heroin addict culture, which is now flourishing.<sup>109</sup>

New York State accounts for nine to ten million prescriptions for controlled drugs yearly. The medical necessity for this volume of prescribed dangerous drugs is questionable.<sup>110</sup> These drugs include the barbiturates, first introduced into medical practice in 1903; amphetamines, popularized in the late 1930's; and the non-barbiturate tranquilizers introduced more recently. The barbiturate and non-barbiturate sedatives, particularly fashionable now, are not only addicting but their side-effects are destructive and withdrawal from them can cause death. In this respect, they are intrinsically more dangerous than heroin, a tranquilizer which causes few deleterious side effects and from which withdrawal is not fatal.

These drugs have been widely prescribed in the United States,

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<sup>109</sup> Estimates indicate as many as 70% of New York City teenagers experiment with drugs, 45% of high school students and 20% of junior high schoolers currently use them. See Addiction Services Agency Report of May, 1972.

<sup>110</sup> In 1972, the federal government restricted manufacture of amphetamines to a quota which cut the amount produced by 80% from the prior year. There was no reported shortage of these drugs for medical use and the expectation is that the 1973 quota will be half that of 1972.

particularly in the post-war period. In some instances, they have been prescribed too casually, without adequate regard for their potential abusability by the patient or his children. There has been insufficient awareness of the dangers of using some drugs in conjunction with others. This lack of awareness is particularly prevalent among users of non-barbiturate tranquilizers, the effects of which are highly potentiated by mixing them with alcohol or other sedatives.

Barbiturates and alcohol have become a popular combination. Because the effect of both drugs taken together is more potent than a simple additive effect, the combination provides a "cheap" and "smooth" intoxication. Barbiturates and heroin are increasingly combined in New York State. A 1972 study<sup>111</sup> reported that 45 percent of heroin addicts abused barbiturates; 29 percent used barbiturates *before* heroin. Since New York State ranks among the top three barbiturate-abusing states,<sup>112</sup> we have cause to note a high correlation between assaultive crimes, which have been rising in New York City, and barbiturate abuse.<sup>113</sup>

One of the most dangerous aspects of the abuse of drugs by younger teenagers is their indiscriminate ingestion of whatever drugs happen to be available. They hold "fruit salad" parties to which they bring an assortment of mood-altering drugs (*e.g.*, amphetamines, non-barbiturate tranquilizers, barbiturates), often simply taken from their family medicine chest, choose some at random and eat them. Many end their party at the hospital, where doctors do not know for which drug to treat them first. Some die.

Another current fad is the "Juice Bars," whose habitués "dance, faint and pop pills."<sup>114</sup> The fact that the drugs on which they get "stoned" are the same ones their parents — or others — use by medical prescription obfuscates the danger they pose.

Despite growing awareness of the potential dangerousness of many drugs, and of a prevailing drug culture, one out of six television com-

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<sup>111</sup> SEN. SUBCOMM. ON JUVENILE DELINQUENCY, REPORT ON BARBITURATE ABUSE (1972). The report also refers to studies of barbiturate abuse among heroin addicts in England which link the increased abuse of barbiturates to the diminished supply of amphetamines resulting from stricter control over the latter.

<sup>112</sup> *Id.* New York City police seized 172,518 dosage units in 1968, 880,353 in 1970 and a total of 2.5 million units between 1967-1971, inclusive. Arrests for the illicit sale of amphetamines and barbiturates in New York City rose from 93 in 1967 to 676 in 1971.

<sup>113</sup> A United States Bureau of Narcotics and Dangerous Drugs study of 1889 persons arrested for non-drug felony charges in six cities, including New York, found that 17% were barbiturate abusers and that these had the highest rate of aggravated assault among all arrested drug users (11.35%, as opposed to 3.1% for heroin users and 6.7% for amphetamine users).

<sup>114</sup> See *HiLo*, Dec. 11, 1972, at 61, for Julie Baumgold's descriptive report.

mercials is "pushing" a drug. Medical journals carry ads for mood-altering drugs which promise effective help for a variety of disabilities, including "environmental depression."

The House Select Committee on Crime, investigating the relationship between drug commercials and drug abuse, found that "the proliferation of television drug advertisement is contributing to our national drug crisis."<sup>115</sup> However, a ban on such commercials originally proposed by the report was later erased, and a committee spokesman explained that "vigorous lobbying by the network industry persuaded members to scratch the ban from our report."<sup>116</sup>

Furthermore, until the 1973 amendments to article 220 of the Penal Law, effective September 1, 1973, possession of any amount (including a warehouseful) of dangerous but not contraband drugs (*e.g.*, amphetamines and barbiturates), has been only an A misdemeanor, punishable by imprisonment for not more than 1 year.<sup>117</sup>

Official note has now been taken of both the proliferation of poly-drug abuse and of the diminishing age of abusers of these drugs. Government action has been initiated but has left room for improvement. In 1970, New York State enacted the Youthful Drug Abuser Treatment Act,<sup>118</sup> aimed primarily to help children under 16, and authorized NACC to receive and allocate \$65 million to localities. As of November, 1971, \$31 million in federal, state, city and private funds had been allocated to the Youthful Drug Abuser Program (70 voluntary drug-free treatment facilities with diverse approaches serving 5,000 persons under age 16). The Act provided funds to localities expressly to stimulate programs to be "conducted in facilities located close to those served and [to] speed rehabilitation and restoration by involving families and community resources to the greatest extent possible."<sup>119</sup> One year later, however, the Community Service Society noted that most of the programs it observed had been unable to gain any appreciable

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<sup>115</sup> H.R. REP. NO. 93-357 (1973).

<sup>116</sup> See N.Y. Post, Feb. 8, 1973. H.R. REP. NO. 93-357, acknowledges the guidelines of the National Association of Broadcasters Code Review Board (effective September 1, 1973) regulating the substance of advertising of non-prescription drugs but not their number, and comments: "It is, perhaps, validly asserted that saturation can lead to a casual acceptance of drugs as a necessary component to an everyday existence." *Id.* at 52.

<sup>117</sup> The New York State Temporary State Commission to Evaluate the Drug Laws recommended, in 1972, that illicit possession of large quantities of any controlled substance be a felony but its bills stalled in committee.

<sup>118</sup> This was accomplished by amending section 213-a, now section 81.36, of the Mental Hygiene Law, the statute which established the Narcotic Addiction Control Commission, Ch. 607, § 2, [1970] N.Y. Laws 2208. In 1971 the law was amended to include all drug abusers under the age of 24. Ch. 817 § 1, [1971] N.Y. Laws 2041.

<sup>119</sup> Ch. 607, § 1, [1970] N.Y. Laws 2207.

family cooperation and were not (yet) sufficiently rooted in their neighborhoods to make use of available resources; and that "too little attention was given to the need for careful planning and assignment of responsibility for carrying out the program."<sup>120</sup>

In response to poly-drug abuse, the 1972 Legislature, addressing the question of how the children of this state are getting the drugs they are eating, enacted the Controlled Substances Act,<sup>121</sup> which far more stringently regulates the manufacturing, distributing, and dispensing of dangerous drugs. The intent of this Act is to prevent diversion of these drugs to the street market and to alert the medical profession and the consumer to the necessity for judicious use of them. Early informal reports on the effect of the Controlled Substances Act indicate that fewer of the more dangerous drugs are being prescribed, suggesting a keener awareness of the dangers inherent in their use.<sup>122</sup> It is essential that there be ongoing evaluation of the scheduling of drugs in this Act, so that the placement of each drug on a schedule realistically reflects its dangerousness, abusability, and the extent of its diversion to the illicit market.<sup>123</sup>

Additionally, the 1973 state Legislature changed the title of the state's umbrella commission from Narcotic Addiction Control Commission to Drug Abuse Control Commission (DACC), authorized DACC to receive drug dependent persons, and defined such as a narcotic addict or a person who is dependent upon a listed controlled substance.<sup>124</sup> Guidelines for the content and modality of treatment programs for such persons have not yet been issued.

### *Prevention*

Beyond the preventive effect of drying up the source of supply, a goal paramount in the Controlled Substances Act and implicit in the

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<sup>120</sup> Community Service Society Comm. on Youth and Correction, *Treatment Programs for New York City's Youthful Drug Abusers* (Dec. 1972, Information Paper). The paper also urges field research leading to the design of more effective treatment programs, the responsibility of government to monitor and assess programs, and that more attention be given to planning and coordinating services.

<sup>121</sup> Ch. 878, [1972] N.Y. Laws 3296. For details, see 1972 N.Y. Lec. Doc. No. 10 (1972) (interim report of N.Y. State Temp. Comm'n to Evaluate the Drug Laws). The Act took effect April 1, 1973, but some of its provisions are being litigated.

<sup>122</sup> Prescriptions for drugs in Schedule II, which includes amphetamines, have decreased noticeably, since April 1, 1973, according to Sal Rubino, President, New York State Pharmaceutical Society.

<sup>123</sup> In 1973, methaqualone (Quaalude, Sopor) was added to Schedule II of the N.Y.S. Controlled Substances Act, N.Y. PUB. HEALTH LAW § 3306 (McKinney Supp. 1973), subjecting it to the most stringent regulation. This is a non-barbiturate tranquilizer which gained instant popularity when word went out that it was an aphrodisiac. Actually, an overdose can cause coma, convulsions and death.

<sup>124</sup> Ch. 676, [1973] N.Y. Laws.

revised penal law, prevention has been largely limited to superficial and inept "education" programs.<sup>125</sup> Funds for programs to prevent the abuse of dangerous drugs were provided in the Youthful Drug Abusers Act, and there *are* some programs which attempt to intervene in students' life-styles and to provide socially acceptable gratifications and avenues of achievement.

New York City's Addiction Service Agency Proposed Guidelines for 1973-74 School-based Prevention Programs stress "intervention strategy" which has as its "major goal" the "change of behavior and attitudes," and as its activities group and individual counseling and special classes.<sup>126</sup> While negative behavior and attitudes may cause one to fail to take advantage of existing opportunities, a change of attitude is only half the coin. The opportunities must really exist.

The danger in the American approach to prevention lies in over-concentration on the narrowest of symptoms and concurrent neglect of basic human needs. For instance, New York puts money into drug abuse prevention education, from fourth grade up,<sup>127</sup> and at the same time New York City cuts back the number of nurses in its public schools from the 900 of 30 years ago to 318 today (for over 900,000 children). The message to a child is clear: If you want attention and help, get on drugs. The best one can expect from such an approach is to move people from one symptom to another.

New York State has now provided a multiplicity of treatment modalities for those already addicted in numbers approaching sufficiency; we have recognized that rehabilitation often means social as well as medical treatment; we have opted to use penal sanctions for possession to encourage addicts to seek treatment; and we have strengthened our penalty structure for traffickers.

But we cure addicts of their heroin habit only to find many are

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<sup>125</sup> N.Y. MENTAL HYGIENE LAW § 81.36(c)(2)(ii) (McKinney Supp. 1973) mentions prevention only as "preventive education services," which "shall mean and include activities, designed to alert and prevent the onset of drug abuse and addiction, such as referral services, speakers' bureaus, and public information services, in which the contact of the provider of services with potential drug abusers, experimenters, parents or others is not on a regular, ongoing and sustained basis." The National Coordinating Council on Drug Education, studying films used in preventive campaigns, found only 16% of the 220 films reviewed to be "scientifically and conceptually acceptable," and branded seven films specifically produced for showing to minority groups "stereotyped and racist" [sic].

<sup>126</sup> For those not on drugs, ASA urges reinforcement of a student's ability to achieve and have impact on his environment through such activities as "light" rap sessions, parent work shops and seminars, school personnel seminars, and development of "so-called humanistic or affective educational approaches." The fact that an outside agency considers it necessary to suggest to the Board of Education that educational approaches be humanistic, or at least that those funded by DACC be so, is disconcerting.

<sup>127</sup> \$23 million appropriated in New York State 1972-1973.



abusing alcohol and barbiturates. We succeed in decreasing crimes associated with addiction, only to find that crimes of violence are increasing.<sup>128</sup> It is time now to think more of people and less of the drugs they take.

It is time to concentrate on prevention and to define prevention in positive terms, providing what people need, rather than in negative terms, dissuading people from using a drug. The only real deterrent to a child's self-destructive behavior, such as drug abuse, is his respect for himself and his body; and this respect is largely a reflection of society's valuation of him, as expressed in the physical and emotional and intellectual care it gives. The best hope of preventing adult anti-social or self-defeating behavior, including drug abuse, is to provide the avenues and tools an adult needs to contribute meaningfully.

It is time to examine the reasons underlying this nation's pervasive dependence on mood-altering drugs.

In the last 25 years a number of "symptoms" have flared: juvenile gangs, heroin addiction, abuse of other drugs, campus unrest, riots, and now, increasingly, individual acts of violence — aggravated assaults, rapes, and murders.

If society continues to treat only the symptom, we may well persuade addicts to turn to other drugs, or drug abusers to turn to something else, only to face a worse conflagration.

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<sup>128</sup> In the first 8 months of 1971-1972, burglary declined by 15% and larceny by 26%. Murders, forcible rape, and aggravated assault increased.