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What is the British approach to the problem of narcotics addiction? Is there a so-called "British System" which differs radically from American policies? On the basis of two years' research in England studying British addiction policies in operation, Dr. Schur here presents his answers to these timely and important questions. In addition, he not only appraises the effectiveness of the British approach but also considers whether the British experience may be a helpful guide in reforming American policies.—EDITOR.

INTRODUCTION

There has been developing in recent years an increased interest in possible modifications of the current American narcotics policies. In this regard the British practice relating to drug addiction has been mentioned as a model which might be worthy of imitation. Although at least two authoritative descriptions of the British approach to this social problem recently have been published in the United States (one written by a British medical practitioner, the other by an American sociologist),[1] a considerably distorted picture of the British policies seems to continue to enjoy fairly wide circulation. The object of this paper is to throw some additional light on a few points of contention regarding such policies. The conclusions reached here are based on two years' research in England studying British addiction policies in operation.[2]

Since the aforementioned articles described fully the relevant legal provisions, it should suffice here merely to summarize briefly the basic elements of British addiction law. Under provisions of the Dangerous Drugs Act,[3] stringent control is placed on the possession and supply of such drugs as opium, heroin, morphine, pethidine (Demerol), methadone (Amidone), and cocaine.[4] Persons authorized to handle such dangerous drugs are required to keep careful records of all drugs received and supplied, and these records are routinely examined by the Home Office and by special Ministry of Health inspectors. Dangerous drugs must be kept in locked receptacles and prescriptions for such drugs are subject to special rules. Although the Government urges doctors to exercise great caution in the supplying of narcotics to patients, physicians may in fact (if certain

[1] Bishop, *A Commentary on the Management and Treatment of Drug Addicts in the United Kingdom*, in NYSWANDER, THE DRUG ADDICT AS A PATIENT 148 (1956); Lindesmith, *The British System of Narcotics Control*, 22 LAW & CONTEMP. PROB. 138 (1957).

[2] As well as examining various official documents, the writer gained useful information through the following: personal interviews with officials of the Dangerous Drugs Branch of the Home Office, and with physicians, psychiatrists and pharmacists having experience in cases of addiction; questionnaire responses of thirteen British medical specialists having experience in over four hundred cases of addiction encountered in a variety of settings; information about twenty-one "representative" addict-patients, provided by these specialists; detailed case studies of five addicts, four through lengthy personal interviews; a questionnaire survey of all general practitioners registered with the National Health Service in one Greater London borough; and a sample survey of 147 21-year-olds in the same borough—inquiring into contact with narcotic drug use, knowledge of the drug laws and attitudes towards addiction. See SCHUR, DRUG ADDICTION IN BRITAIN AND AMERICA: A SOCIOLOGICAL STUDY OF LEGAL AND SOCIAL POLICIES (1959) (unpublished doctoral thesis, University of London). In the present article it is not possible to deal at any length with the American narcotics situation. Readers unfamiliar with the American policies may wish to consult Cantor, *The Criminal Law and the Narcotics Problem*, 51 J. CRIM. L., C. & P.S. 512 (1960); NYSWANDER, *op. cit. supra* note 1; the symposium on *Narcotics*, 22 LAW AND CONTEMP. PROB. (1957); *Narcotics Regulation*, 62 YALE L. J. 751 (1953); ANSLINGER & TOMPKINS, THE TRAFFIC IN NARCOTICS (1953), as well as other general works on narcotics addiction. A particularly pungent critique of American policy was provided by Lindesmith, *"Dope Fiend" Mythology*, 31 J. CRIM. L. & C. 199 (1940); for an opposing view see Michelson, *Lindesmith's Mythology*, 31 J. CRIM. L. & C. 375 (1940).

[3] 14 & 15 GEO. 6, c. 48 (1951). This statute repealed several previous Dangerous Drugs Acts, consolidating the provisions of all such prior laws.

[4] Cannabis, or marihuana, is also subject to control under this law, but as in the United States it is not commonly used in medical practice. The key differences between British and American narcotics policies relate to the prescription of the distinctly addictive opiates and opiate-type drugs and (occasionally) cocaine.

broad conditions are met) legally supply narcotics to addicts.[5] Doctors who improperly divert narcotic supplies to their own use, or who otherwise violate provisions of the drug laws, are subject to fine or imprisonment; furthermore, the Home Secretary may, on conviction for an offense against the Act, withdraw a doctor's authority to possess, prescribe or distribute dangerous drugs. There is no formal state registration of addicts, but doctors are requested to inform the Home Office of any addicts who come under their care. There is no provision for compulsory treatment of drug addicts in the United Kingdom, and "There are no State institutions specialising in the problems of drug addiction, but treatment can be obtained at a number of public hospitals; a small number of private nursing homes most of them primarily concerned with alcoholics, also accept drug addicts."[6] Finally, and crucially, it should be noted that, "to be a drug addict has never been and is not now illegal in this country. The addict is committing an offence only if drugs found in his possession have been unlawfully obtained."[7]

To combat American expressions of interest in this non-punitive medically-oriented approach, defenders of current drug policies in the United States promote two views of the British policy. Either it is argued that the British approach essentially is no different from that in this country, or, alternatively, it is maintained that the British approach is too different, too radical, that it has had bad results in Britain and should not even be considered as a possibility here. It may be useful to consider these views in the light of actual British practices regarding the control and treatment of addiction.

The British Approach Is Different

An anonymous mimeographed statement about the "British Narcotics System"[8] contains the claim that, "The British system is the same as the United States system."[9] Similarly, the 1956 Senate investigation of narcotics traffic elicited testimony that, ". . . the English system is, for all practical purposes, the same as our own in this continent, in the United States and Canada."[10] In the same hearings, Mr. J. H. Walker, the United Kingdom delegate to the U.N. Narcotic Commission, was quick to stress that, ". . . dangerous drugs are subjected in the United Kingdom to a wide degree of control and the exacting standard demanded by the international agreements to which . . . the United Kingdom is a party. The indiscriminate administration of narcotics to addicts would be incompatible with those obligations and is not now, and never has been, a feature of United Kingdom policy."[11] Testimony before the Canadian Senate, reprinted in a recent report on the British system distributed by the U.S. Federal Bureau of Narcotics, includes the statement: "the authorities advise that they are quick to take appropriate action whenever a

[5] The guiding principle in this regard continues to be that laid down by a Departmental Committee in 1926: ". . . morphine or heroin may properly be administered to addicts in the following circumstances, namely, (a) where patients are under treatment by the gradual withdrawal method with a view to cure, (b) where it has been demonstrated, after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced, (c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued." Ministry of Health, Departmental Committee on Morphine and Heroin Addiction, Report, 19 (1926). This statement is reprinted in the circular distributed by the Home Office, The Duties of Doctors and Dentists under the Dangerous Drugs Act and Regulations, 14 (D.D. 101, 6th ed., 1956).

[6] Home Office, Report to the United Nations on the Working of the International Treaties on Narcotic Drugs for 1957, 4.

[7] Bishop, *op. cit. supra* note 1, at 150.

[8] Distributed by, and presumably prepared by, the Federal Bureau of Narcotics. This pamphlet was circulated at the 1954 meeting of the American Prison Association. For further discussion of this statement see Lindesmith, *op. cit. supra* note 1, at 151–52.

[9] In support of this claim reference is made to the Home Office's statement that, "The continued supply of drugs . . . solely for the gratification of addiction is not regarded as a medical need." See Home Office, The Duties of Doctors and Dentists, *op. cit. supra* note 5, at 2. It is quite true that the British authorities serve up this warning to medical practitioners, but it is highly misleading to quote this statement by itself as an indication of the general tenor of British policy. This statement must be read in the light of the principle quoted in note 5, *supra*. As will become clear later in this article, the British basis for determining what constitutes "medical need" for the administration of narcotics differs strikingly from the basis for such determination in the United States.

[10] Statement of Dr. G. H. Stevenson, director of drug addiction research in the University of British Columbia. *Hearings Before the Subcommittee on Improvements in the Federal Criminal Code of the Senate Committee on the Judiciary*, 84th Cong., 1st Sess., pt. 5 (hereafter referred to as "*Daniel Hearings*"). A more complete statement of Stevenson's views may be found in a reprint circulated by the Narcotics Bureau. Stevenson, *Arguments For and Against the Legal Sale of Narcotics*, reprinted from 31, No. 4 Bull. of the Vancouver Med. Ass'n.

[11] *Daniel Hearings*, *op. cit. supra* note 10, at 1770.

case comes to their attention that a doctor is supplying drugs to an addict."[12]

Assertions that British and American drug policies are the same are totally misleading. It is true that in Britain drugs are subject to "a wide degree of control," that there is no "indiscriminate" prescribing for addicts, and that the authorities take "appropriate action" where necessary. But what these statements mean in practice is determined by the general tenor of British narcotics policy, and this overall outlook is sharply divergent from that which determines American policy. The major point on which the two approaches differ is the degree of freedom accorded the medical profession as regards the treatment of addiction. Within broad limits, the British doctor has almost complete professional autonomy in reaching decisions about the treatment of addicts. When a responsible medical practitioner determines that an addict needs drugs, it is very unlikely that this prescribing will be considered to be "for the mere gratification of addiction." This follows from the fact that in Britain addiction is officially recognized as a medical problem. As the Home Office recently stated in a report on addiction, "In the United Kingdom the treatment of a patient is considered to be a matter for the doctor concerned. The nature of the treatment given varies with the circumstances of each case."[13] This writer recently asked a Dangerous Drugs Branch official how often legal proceedings are instituted against doctors for improper prescribing of drugs to addict-patients. The official could recall only two or three cases where there were prosecutions for what was felt to be overprescribing. But he stated that these prosecutions were unsuccessful because the courts are unwilling to convict the doctor in such instances; if the doctor states that the patient needed the amount prescribed, the court ordinarily will uphold his professional judgment. Apparently most of the checking-up on doctors who are found to be prescribing narcotics regularly is undertaken with a view to uncovering doctor-addicts who are prescribing for fictitious patients.[14]

A related point of importance is that in Britain the medical profession and law enforcement officials are in general agreement concerning the proper approach to the addiction problem: addicts are patients, not criminals. An early and influential expression of this view—which is held in common by almost all those who are professionally concerned with addiction—was provided in 1926 by the Departmental Committee on Morphine and Heroin Addiction. The committee asserted that, "With few exceptions addiction to morphine and heroin should be regarded as a manifestation of a morbid state, and not as a mere form of vicious indulgence."[15] My own research and observations

[12] Excerpt from statement of Hon. Paul Martin, in "Advisory Committee to the Federal Bureau of Narcotics, The British System," July 3, 1958, mimeo, p. 9.

[13] HOME OFFICE, REPORT TO THE UNITED NATIONS, *op. cit. supra* note 6, at 5.

[14] Even when such instances are discovered the doctor is treated leniently. Usually he is prosecuted, but the typical sentence is a fine (and ordinarily he will lose his authority to possess, prescribe or supply Dangerous Drugs; he may, however, continue to practice medicine). The Dangerous Drugs official could think of no case in which a doctor-addict had been sent to prison. The doctor's broad responsibility in the treatment of addicts is not enjoyed by his American colleague. While there is no provision in the basic federal narcotics law (the Harrison Act) which specifically prohibits doctors from treating addicts, the U.S. Narcotics Bureau persistently has interpreted the Act to have that meaning. Treasury Department regulations require that prescriptions for narcotics be for "legitimate medical purposes" only, and state further that, "An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law." U.S. Treas. Reg. No. 5, Art. 167, as reprinted in BUREAU OF NARCOTICS, PRESCRIBING AND DISPENSING OF NARCOTICS UNDER HARRISON NARCOTIC LAW (1956). The same pamphlet also contains the warning that, "This Bureau has never sanctioned or approved the so-called reductive ambulatory treatment of addiction for the reason that where the addict controls the dosage he will not be benefited or cured." *Id.* at 8. At least one legal critic contests this interpretation—stating that the Bureau has substituted its own views for the real intent of the Act (which had nothing to do with addicts), and that it has acknowledged only those court decisions favoring its position while ignoring other, less favorable judicial holdings. See King, *Narcotic Drug Laws and Enforcement Policies*, 22 LAW AND CONTEMP. PROB. 113 (1957); and *The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick*, 62 YALE L. J. 735 (1953). Additional stringent federal legislation (including the Narcotic Control Act of 1956) and a vast array of anti-narcotics measures in the various states (some of which have now made addiction, *per se*, a crime) further support the Bureau's approach to the addiction problem. *Ibid.* The practical consequences of these measures and interpretations are that: *American physicians have been prevented from prescribing drugs for addicts, even in (ambulatory) withdrawal treatment. In Britain the doctor has the freedom to undertake withdrawal treatment, and also in many cases may legally prescribe drugs for addicts not currently undergoing such treatment.*

[15] DEPARTMENTAL COMMITTEE ON MORPHINE AND HEROIN ADDICTION, *op. cit. supra* note 5, at 31.

in Britain lead me to believe that Bishop is quite right in maintaining that, "There is a very real spirit of cooperation between the medical profession and Government and Police authorities which has helped a great deal to keep this country free from organised drug trafficking."[16] Although United States narcotics policies have at times coincided with the views of the American medical profession, recent developments, which are described below, suggest that medical approval of such policies is definitely waning. At any rate it is well known that (in contradistinction to the British situation) the keynote of American policy has been punitiveness. Despite official efforts to "cure" addicts, the addict has been treated primarily as a criminal, not as a patient. In some instances the punitive nature of American policy imperils even modest efforts at medical evaluation of addicts.[17]

British Policy Succeeds

The recent assessment of British policy distributed by the Federal Bureau of Narcotics includes a reference to, "The unfortunate narcotic situation in the United Kingdom."[18] The present writer is unable to see any factual basis for such an assertion. At no time since the passage of the original Dangerous Drugs Act in 1920 has the amount of recorded addiction risen to an alarming level. Current estimates place the number of addicts between 300 and 500. It is particularly significant that the estimated prevalence of addiction actually has decreased over the years; in 1935 the Government estimated a total of 700 addicts whereas in 1957 the estimated number was 359.[19] Undoubtedly these official figures on known addicts somewhat understate the actual number of addicts, but there is no evidence of any large number of addicts besides those receiving their drugs through legal channels. As Lindesmith has pointed out,[20] one reason for believing that there are few concealed addicts is the fact that few addicts are sent to prison; assuming competent police work, addicts relying solely on black market drug sources would invariably incur prosecution and imprisonment. It is easy to understand why there are few illegally-supplied addicts. Previous accounts of the British drug policies have stressed the fact that legal provision of drugs at a nominal cost under the National Health Service has taken away the economic incentive which supports illicit narcotics traffic. Why should the addict pay for drugs, at the same time risking liability for narcotics violations, when usually he can obtain them legally from a doctor? All the available evidence supports the claim that there is hardly any illicit traffic in opiates. A Home Office official told the writer that he could not even recall a case involving heroin trafficking in recent years. According to several British addicts, the small illicit traffic which does exist supplies mostly "joy poppers" and other experimenters who could not obtain drugs through medical channels, as well as some recently-addicted persons who are afraid of contact with "the law." And probably this small black market is limited geographically as well as numerically. One London addict informed me that, "_____ Street is about the only place. You can't get it anywhere else. Leave _____ Street, you leave it all behind."

Some critics of the British approach to addiction have alleged that, "There is a very considerable black market for hashish (marihuana) in the United Kingdom. . . ."[21] Quite apart from the fact that the rate of marihuana use may not be directly relevant to a discussion of policies toward opiate addiction, there is no real evidence to back up this charge. There may be a minor trend toward

[16] Bishop, *op. cit. supra* note 1, at 153.

[17] "[I]t is our feeling that use of our clinic by the Narcotics Court was not motivated by any clear understanding of the problem; frequently punitiveness, exhibitionism, and at times confusion in regard to guilt of the patient were the motivating causes for referral. Something of this is understandable from the fact that apparently the whole narcotics drive had many aspects of immaturity itself—it was an impulsive gesture designed to rid the city *at once* of a problem which is deep-rooted in the very nature of our western culture.

"The function of a court clinic in a 'drive' such as this is a difficult one. Normally the function of a court clinic is fairly well-defined—but under the extreme pressures brought to bear upon us by the Court, the Police Department, the newspapers and interested lay groups during such a drive, it is a struggle to preserve professional integrity, and not to become involved in legalistic and political maneuvering." McFarland & Hall, *A Survey of One Hundred Suspected Drug Addicts*, 44 J. Crim. L., C. & P.S. 317 (1953).

[18] "Advisory Committee to the Federal Bureau of Narcotics," *op. cit. supra* note 12, at 14.

[19] The former estimate is reported in Adams, Drug Addiction 37 (1937); for the latter see Home Office, Report to the United Nations, *op. cit. supra* note 6, at 5.

[20] Lindesmith, *The British System of Narcotics Control*, *op. cit. supra* note 1, at 141–42.

[21] "British Narcotics System," *op. cit. supra* note 8, and adjoining text.

increased use of marihuana in certain circles.[22] But the overall prevalence of such drug use is not high. In 1955 only 115 persons were prosecuted for offenses involving marihuana; in 1957 the number was 51. Some findings from the present writer's survey of a sample of 21-year-olds in a Greater London borough may also be relevant to this question. When presented with the statement, "A 'reefer' looks like (check one)—A Pipe ____ A Cigarette ____ A Hypodermic Injection ____ Don't Know ____", only 76% were able to state the correct answer. Twenty-one per cent checked "Don't Know." Of 147 respondents, only seven (5%) reported having seen someone using a reefer and only one had tried to obtain a reefer for himself. While colored persons were probably underrepresented in my sample, these results still suggest that knowledge of and contact with marihuana has not in fact spread widely throughout the population.

Just as lack of economic incentive inhibits the development of a large-scale illicit traffic in drugs, low-cost provision of drugs means that the addict need not turn to criminal activities in order to finance his habit. Already noted has been the significant fact that very few addicts are imprisoned for any sort of offense. According to a Home Office official, those addicts who do go to prison usually have committed "minor violations of the narcotics laws in order to get a bit more drug than the doctor was providing." In 1957 the few addicts convicted of drug offenses either had obtained drugs from chemists by forged prescription or had gotten supplies from more than one doctor.[23] Addicts then do not often become criminals, and by the same token underworld and criminally-prone elements are not particularly likely to come into contact with addiction. It is especially noteworthy that juvenile delinquency and addiction have not become intermeshed, as they have to a considerable extent in the United States. Dr. T. C. N. Gibbens, a leading British forensic psychiatrist, has studied 200 boys aged 17–21 sent to Borstal institutions from the London area (one hundred in 1953—every other lad sent to Borstal in the Metropolitan Police Area for about nine months—and a similar number in 1955). He has also seen about 700 wayward girls aged 14–17 in a London remand home between 1951 and 1958. Among the boys, "there were no cases with any experience of addiction." As to the wayward girls, "about 1% claimed to have had a reefer offered to them, usually by U.S. service boy-friends, or sometimes in clubs, and there were no cases approaching addiction. . . ."[24] All the available evidence supports the Government reports that most of the British addicts are over 30 years of age. The experience of medical practitioners who have treated addicts attests further to the general separation of addiction and criminality in Britain. In response to the question, "How many of the addicts you've seen do you think likely to have close friends in the criminal underworld?", none of the thirteen specialists questioned by the writer thought that either "practically all" or even "many" of the addicts had such underworld connections. Seven specialists answered "a few," and four answered "none." Two said "about half." Similarly most of these specialists indicated that only "a few" or "none" of the addicts they had observed seemed to identify themselves with a criminal role and way of life. It would seem that the policy of refusing to label the addict a "criminal" has in fact had the effect of helping to insulate addicts from criminal contacts and activities. The fact that there is little addict-crime in Britain lends strong support to the mass of American evidence showing that addicts in the United States commit crimes mainly to obtain funds to support their habit. One certainly finds in Britain nothing to uphold the argument that most addicts are basically criminals anyway, that criminality precedes addiction rather than stemming from the peculiar situation

[22] Bishop, for example, refers to a group of drug users who "are often coloured dance band players but may also be white English men and women. These are the adolescents who frequent the cheap dance halls. They smoke a 'reefer' in an attempt to show off in a daredevil spirit or because they have been told it will make them more 'sexy.'" Bishop, *op. cit. supra* note 1, at 158.

[23] HOME OFFICE, REPORT TO THE UNITED NATIONS, *op. cit. supra* note 6, at 8.

[24] Dr. Gibbens writes further: "One psychopathic girl recently, a lesbian and prostitute and approved school absconder, claimed to have taken reefers a fair bit and to need them, and another similar girl seen in 1952 was followed up in prison recently and she had had a spell of 'drug-taking' but had passed on to other matters with no trouble. That's really the lot, at least of any gravity. These 700 represent nearly all the seriously wayward girls in London of 14–17 who came before the juvenile courts in need of care or protection." Personal letter to the writer. I am grateful to Dr. Gibbens for permission to reproduce these unpublished data.

of the American addict.[25] The lack of criminality among British addicts also seems to contradict the argument that legal dispensing of drugs will not really curb criminality because addicts will never be content with the legally-provided drugs.

The British approach furthermore has limited the emergence of a distinct addict subculture. Albert Cohen has written that, "The crucial condition for the emergence of new subcultural forms is the existence *in effective interaction of a number of actors with similar problems of adjustment.*"[26] Unlike what happens in America, addicts in Great Britain are not completely cast out of respectable society, and there is no special likelihood that ordinarily they will find themselves "in effective interaction" with one another. And while they may have certain "similar problems of adjustments"—in the sexual and occupational realms for example—the problems they encounter more often call for individual rather than group solutions. They are not subjected (as are the American addicts) to a constant struggle for economic survival, for drug supplies, and for anonymity in the face of relentless police action and a hostile public. British addicts are not, *ipso facto*, members of an addict subculture.

Possibilities for Reform in America

Several important proposals for reforming American addiction laws have embodied the spirit if not the letter of the British approach. One of the first of these proposals appeared in the report of a committee of the New York Academy of Medicine in 1955.[27] The committee stated that, "There should be a change in attitude toward the addict. He is a sick person, not a criminal. That he may commit criminal acts to maintain his drug supply is recognized; but it is unjust to consider him criminal simply because he uses narcotic drugs.... The Academy believes that the most effective way to eliminate drug addiction is to take the profit out of the illicit drug traffic...." To this end the Academy proposed a program for the legal dispensing to addicts of low-cost drugs, at federally controlled dispensary-clinics throughout the country. Such clinics, it was felt, also would provide a setting within which intensive efforts to treat addicts could be made and would afford opportunities for the collection of much useful information about addiction. As the late Dr. Hubert Howe, author of the plan, testified: "We are not saying to give the addicts more drugs. We are simply advising a different method of distribution. The Government says he cannot get it legally; therefore, he has got to steal and rob, and so on, in order to get it.... But every addict gets his drug right now ... why not let him have his minimum requirements under licensed medical supervision, rather than force him to get it by criminal activities, through criminal channels?"[28] Thus the force of some collective professional opinion gave added weight to the earlier calls by influential individuals (including Judge Jonah J. Goldstein and Magistrate John M. Murtagh in New York) for some change in our narcotics laws.

In 1958 a joint committee of the American Medical Association and the American Bar Association released a report expressing grave dissatisfaction with current American addiction policies.[29] The core of this committee's proposals was that a small "experimental" clinic program should be set up. Presumably this procedure would offer an opportunity of testing (without the risk of any widespread adverse consequences) how well a carefully run system of dispensing low-cost narcotics might work. It would also enable researchers to discover, under experimental conditions, the administrative problems which would have to be considered in the development of any larger program. This proposal followed the important 1957 report on addiction of the American Medical

[25] This latter argument is stated with regularity by American narcotics officials. *E.g.*, "In addition to suppressing the traffic in narcotics, police activity against drug addicts is a very essential part of general police operations. The great majority of addicts are parasitic. This parasitic drug addict is a tremendous burden on the community. He represents a continuing problem to the police through his depredations against society. He is a thief, a burglar, a robber; if a woman, a prostitute or a shoplifter. The person is generally a criminal or on the road to criminality before he becomes addicted. Once addicted he has the greatest reason in the world for continuing his life of crime." Anslinger & Tompkins, *op. cit. supra* note 2, at 170.

[26] Cohen, Delinquent Boys: The Culture of the Gang 59 (1955).

[27] New York Academy of Medicine, Subcommittee on Drug Addiction, *Report*, 31 Bull. N.Y. Acad. of Medicine 592 (1955); see also Nyswander, *op. cit. supra* note 1, at 162–70.

[28] Hubert S. Howe, M.D., in *Daniel Hearings*, *op. cit. supra* note 10, at 1332. For another statement of Dr. Howe's views see his article, *An Alternative Solution to the Narcotics Problem*, 22 Law and Contemp. Prob. 132–37 (1957).

[29] Reported in N.Y. Herald Tribune, June 25, 1958.

Association's Council on Mental Health.[30] The Council's report contains an extensive review of the whole problem of drug addiction, and includes a brief consideration of the British practice. The Council was not prepared to approve proposals for the establishment of clinics "at this time." It was not sure that such a program would curb all illicit traffic, and it noted the considerable expense and administrative problems involved. However the Council did recommend greatly modified penalties for narcotics law violations; civil rather than criminal commitment of addicts for treatment where possible; extension of opportunities for voluntary admission to treatment facilities; more treatment facilities; and more research. It also asserted both that "There is nothing in the federal narcotic law which prohibits a physician from treating an addict," and that the American Medical Association itself was largely responsible (see below) for the current state of addiction policies. Although recognizing the many difficulties involved in implementing the British approach in the United States, the Council clearly was interested in that possibility. It recommended that the Association revise its earlier policy statements on addiction, and considered including in such a revised statement "a plan endorsing regulations somewhat similar to those currently in force in England."[31]

Despite these signs of increasing professional acceptance of the British outlook on addiction, there remain a number of serious obstacles to reforming the American laws. In the first place there may be some feeling that the British policy does not place enough emphasis on the treatment and cure of addiction.[32] It is true that there is no provision in Britain for compulsory treatment of addicts, and there are no special institutions comparable to the Lexington and Fort Worth hospitals in this country. But this may well represent a realistic recognition of the considerable limitations of withdrawal treatment, and may constitute a humane alternative to a policy aimed at compulsory confinement. As the Ministry of Health committee noted in 1926, in addiction cases, "Relapse, sooner or later, appears to be the rule, and permanent cure the exception. . . ."[33] There is no way of estimating the degree of success achieved in British attempts at curing addicts; almost always there is difficulty in maintaining a satisfactory follow-up on the patient. Probably most British specialists would content themselves with very cautious appraisals, like the one provided the present writer by the nursing sister in charge of a home for alcoholics and addicts: "We are in touch with a number of ex-patients in whom there has been no relapse over a period of years." There is no reason to assume that American officials, who place such great stress on cure, can legitimately claim much more than this.[34] At any rate,

[30] A.M.A., Council on Mental Health, *Report on Drug Addiction*, 165 A. M. A. J. (Nov. 30, 1957; Dec. 7, 1957; Dec. 14, 1957).

[31] *Id.* at 1973 (Dec. 14, 1957). The assertion that "nothing in the federal narcotics law" prohibits a physician from treating an addict refers to the fact that such prohibition (which actually is in effect today) stems primarily from current interpretation of legal provisions and not from the provisions themselves. See discussion *supra* note 14.

[32] Thus physicians testifying before the Daniel Committee expressed the view that the Howe plan and similar proposals amounted to an admission of defeat in the battle against addiction. Similarly, note the following statements: "I think it is fair to say that it [the Howe plan] sort of represents throwing in the sponge." (then N.Y. Attorney General Javits) "It would seem to me that was a defeatist attitude. You just throw up your hands and give up on the problem." (Sen. J. M. Butler) *Daniel Hearings*, *op. cit. supra* note 10, at 1446, 1449.

[33] DEPARTMENTAL COMMITTEE ON MORPHINE AND HEROIN ADDICTION, *op. cit. supra* note 10, at 17.

[34] Medical officers at Lexington stated some years ago, with regard to addicts treated at that hospital, "Follow up reports indicate that over 16 per cent of these patients have remained abstinent over a seven year period, and probably at least an additional 20 per cent have remained abstinent for extended periods of time." Vogel, Isbell & Chapman, *Present Status of Narcotic Addiction*, 138 A.M.A.J. 1025 (1948). Probably these estimates are optimistic. The high rate of relapse may indeed call into question the entire treatment program in the federal hospitals. Dr. Herbert Berger testified before the Daniel Committee: "It is quite probable that the individual who stays for a full course of treatment might well cost the United States Government $2000 to $4000. I am sure these are minimal figures. . . . No one knows the exact rate of relapse. It has been estimated, and I emphasize these are estimates, as being anywhere from 70 to 95 percent. If the rate approaches 90 percent, and most addicts seem to think it exceeds that figure, then that $4000 that we spend for the treatment of one patient becomes $40,000 for cure. Now this is an astronomical figure.

"We in medicine do not accept with equanimity any treatment that fails to achieve cure in even 5 per cent of the cases of any specific disease. Yet the United States Government is committed to a plan of action which fails more than 90 percent of the time." Herbert Berger, M.D., in *Daniel Hearings*, *op. cit. supra* note 10, at 1372.

For a recent assessment of the Lexington and Fort Worth treatment efforts see Winick, *Narcotics Addiction and its Treatment*, 22 LAW AND CONTEMP. PROB. (1957). The hospitals take both voluntary and mandatory (narcotics law violators) patients, and the treatment program includes physical withdrawal from drugs

there is no way of ensuring that an addict who has undergone withdrawal treatment will remain abstinent. As the Lexington doctors themselves have stressed, the withdrawal process is "the least important step in the treatment of narcotic addiction. . . ."[35] There are several reasons for thinking that the British approach holds out a fair hope of effecting meaningful cures. The British policy recognizes that you cannot really force an addict to be cured against his will; treating the addict as a human being, as a troubled person who merits some consideration, may increase the chances of obtaining his cooperation in treatment efforts. (As one British addict assured the writer, compulsory confinement simply won't work: "They can lock you up. All nonsense. Shouting, beating you up, won't get anyone anywhere.") Similarly, the general social situation of the addict in Britain may work to decrease the dangers of relapse, where the addict seriously wishes a permanent cure.[36]

It might also be claimed that the British approach represents merely a grand give-away program, that anyone can walk into a doctor's office and get drugs, and that therefore drug addiction is positively encouraged. Apparently it is difficult even for well-meaning students of addiction fully to accept the non-punitiveness which is implied in recognizing that the addict is a troubled person.[37] Actually there is no need to consider "allowing everyone free access to the drug" the only alternative to a punitive anti-addict policy. It is not the case that in Britain anyone can walk into a doctor's office and get narcotics. Except in rare cases of effective deception, the non-addict cannot get drugs in this way (for regular administration that is—we are not considering here short-term administration for relief of pain). Even the diagnosed addict does not get whatever amount of drugs he desires. As Bishop has stated, "physicians do not *supply* drugs; they try to cure the addict."[38] Except in the small number of cases where the addict is felt to be definitely incurable and where the doctor may be willing to sustain him with a regular dose, most doctors will make some effort to cut down gradually the prescribed dosage. Often this continuing process may reach a point at which either the patient or the doctor will seek to make new arrangements. As one (non-doctor) addict described it, doctors tend to "get fed up" with addicts. Even if the doctor does not get fed up with the addict, the addict may get fed up with the doctor. Often the non-doctor addict will only be content to "stretch" the prescribed dosage so far. Once the real straining point is reached, and unless he is fully dedicated to trying to be cured, the addict may look for a way to supplement the dose or he may try to find a new doctor who will agree to provide a somewhat larger amount of his drug than that to which he has been reduced. This points up a limitation of the British approach (which makes no adequate provision for the addict "between doctors"), but at the same time it makes clear that the approach does not constitute a mere catering to the whims of addicts. There are

(with gradually decreased doses of methadone), vocational and recreational activities, and some kind of psychotherapy. Winick states that, "Every attempt is made to re-educate the patient in a therapeutic environment, and his other ailments are treated. Most patients do not receive effective psychotherapy because of limitations of personnel and time." *Id.* at 24. While most doctors associated with these treatment efforts appear to be generally interested in helping addicts, their efforts may be foredoomed by the overall negative and punitive attitude toward the addict in this country.

[35] Vogel, Isbell & Chapman, *op. cit. supra* note 34, at 1026.

[36] As one psychiatrist has pointed out, ". . . environmental pressures generated by addiction itself help drive the released drug addict on the road to relapse. Back in his home community, a social outcast, frequently with no home, and doubtful prospects of finding legitimate employment, he easily falls under the influence of his former addict associates. The first step toward resumption of addiction is almost invariably precipitated by renewed interpersonal contacts with drug users." AUSUBEL, DRUG ADDICTION: PHYSIOLOGICAL, PSYCHOLOGICAL, AND SOCIOLOGICAL ASPECTS, 90 (1958). In Britain, where the ex-addict need not be a social pariah, and where interpersonal contacts between individual drug users may be limited, the chances for a real recovery may be enhanced.

[37] "It is difficult to appreciate the logic or consistency of regarding the chronic alcoholic as an ill person and the drug addict as a criminal. There is a marked difference, however, between *not* regarding drug addiction as a crime and legalizing the practice, that is, allowing everyone free access to the drug. The suggestion advanced by certain well-intentioned but misinformed persons that the habit be legalized for present known addicts only is unsatisfactory, because it would provide legal and moral sanction for the habit and thus encourage its spread." *Id.* at 15. As is made clear by the British experience, there is no reason to assume the validity of this latter claim.

[38] Bishop, *op. cit. supra* note 1, at 158. This refers primarily to the non-doctor addict. But it is likely (considering the fact that their records are subject to inspection at any time) that even such undisclosed doctor-addicts as may exist carefully limit the amounts of drugs they use. Doctors comprise a high proportion of the known addicts in Britain; such known doctor-addicts ordinarily are under the care of fellow practitioners and are thus receiving carefully limited dosages.

addicts, on the other hand, who remain under medical supervision for long periods of time—sometimes under a single doctor's care. And it is noteworthy that the "between doctors" situation has not led to any large-scale illicit traffic.

Another obstacle to acceptance of the British view is the notion that "public opinion" is opposed to any leniency toward drug addicts.[39] Findings in some American studies do suggest widely held punitive attitudes toward addiction and drug peddling.[40] But it is one thing to recognize this likelihood and another to suggest, as some critics of the British approach seem to do, that drug addiction is so intensely repulsive to all right-thinking people that there is something inherently wrong about a non-punitive addiction policy. Presumably Britons are no less right-thinking than Americans, yet they appear able to accept without great difficulty a humane approach to the addict's problems. This was brought out in the present writer's survey of attitudes among 21-year-olds. In response to the question, "Would you say a drug addict is primarily a sick person or primarily a bad person?", only 2% of the sample said the addict is primarily bad; 80% said addicts are primarily sick, 12% said "both sick and bad" and 6% answered "don't know." When asked, "What should be done with drug addicts? Should they be sent to prison, put in hospital, or merely be left alone?", 93% suggested they be put in hospital, 2% said addicts should be left alone, 5% answered "don't know." *Not one respondent* said that addicts should be sent to prison. It is particularly striking that while (in response to another question) 50% of the sample felt that "Prison is too good for sex criminals; they should be publicly whipped or worse," not even one person prescribed prison for the drug addict. Not having been subjected to a prolonged barrage of invective against addicts, the British public has not developed intense hostility towards them. Even to the extent that this might be because British addicts are actually (as compared with American addicts, for example) relatively harmless, one is still led back to the addiction policies as the key factor. These policies in part determine the behavior of addicts, and they can also directly shape "public opinion" toward addicts.

Sometimes supporters of current American policy cite the very fact that proposed reforms would require legal revision as indicating the undesirability of such reform. This sort of argument, of course, is begging the question—which is, or should be, whether current policies are effective or whether they need changing. Narcotics laws and regulations are not immutable entities, but rather should be subject to rational scrutiny when circumstances demand it. Connected with the call for adherence to (current) "law," is the argument that, "... to conform to the clinic idea, it would be necessary to abrogate the treaties into which the United States solemnly entered along with sixty-four other nations of the civilized world."[41] This argument cannot validly be applied to the British approach. Apart from the fact that Britain has no "clinics," Britain also is a signatory to the various international agreements in question. Her insistence on treating addiction as a medical problem does not appear to contradict the provisions of such agreements.

The foregoing material suggests some of the ways in which American statements have conveyed what this writer considers to be misleading impressions about the British approach to addiction.[42]

[39] The recent A.M.A. report, for example, included the statement that, "If the Association did approve a proposal to legitimize dispensing of opiates to addicts, changes in federal, state, and local laws would be necessary before the plan could be put into operation. It seems very unlikely that such changes can be effected without a marked shift in public opinion." A.M.A., Council on Mental Health, *op. cit. supra* note 30, at 1969.

[40] See Rose & Prell, *Does the Punishment Fit the Crime? A Study in Social Valuation*, 61 AM. J. SOC. 247 (1955); Gilbert, *Crime and Punishment: An Exploratory Comparison of Public, Criminal and Penological Attitudes*, 42 MENTAL HYGIENE 550 (1958).

[41] ANSLINGER & TOMPKINS, *op. cit. supra* note 2, at 191. Critics of reform frequently link the British approach with the American clinic experiment between 1912 and 1925, which it is claimed was markedly unsuccessful. But it is not really clear that these clinics, which provided low-cost drugs for addicts in some forty American cities, were a failure. Accounts of the clinic experience vary considerably, and some writers assert that the government closed the clinics largely on evidence about the New York clinic, which was the least efficient clinic and the least successful. The 1957 A.M.A. report concludes that, "Reasons for closing the clinics are obscure." A.M.A., Council on Mental Health, *op. cit. supra* note 30, at 1709. The Narcotics Bureau's view of the clinics is set forth in the official publication, NARCOTIC CLINICS IN THE UNITED STATES (1955). For an objective analysis of the various reports see NYSWANDER, *op. cit. supra* note 1, at 6–13. The clinic and British approaches have at times been linked in the present article because they do reflect the same general outlook.

[42] Unfortunately there have even been some statements by British officials which contribute to these misunderstandings. For example, a Home Office spokesman is quoted as writing to the Federal Bureau of Narcotics, "we make it clear that there is not in fact any such

Another aspect of the official reaction to interest in the British drug policies has been the persistent resort to vituperative epithets in describing the proponents of reform. Typical was the reference to a leading sociologist as "a self-appointed expert on drug addiction"; this was followed by the statement: "The professor followed the method used by dictators to 'make it simple, say it often'; true or false, the public will believe it. 'Adopt the British system' is now urged by all self-appointed narcotic experts who conceal their ignorance of the problem by ostentation of seeming wisdom."[43] It seems likely that the growing interest in reform exhibited by various professional bodies is going to make it more and more difficult for the Narcotics Bureau to rely on this name-calling. It will have to present solid evidence to back up its point of view if it wishes to prevent revision of the current policies. Particularly significant could be pressure for change from the medical profession. A 1924 resolution of the American Medical Association called on "both federal and state governments to exert their full powers and authority to put an end to all manner of so-called ambulatory methods of treatment of narcotic drug addiction whether practiced by the private physician or by the so-called 'narcotic clinic' or dispensary." This resolution is still cited in support of current American drug policy.[44] If action is taken on the recent recommendation of the Association's Council on Mental Health that this resolution be revised, the impact may be considerable.

Conclusion

There are no available empirical data on the basis of which one can determine whether or not narcotics policies patterned along British lines would work in this country. It is doubtless true, as critics of reform proposals point out, that the addiction "problem" in America is now quite different from that which exists in the United Kingdom. The American problem is enormously larger than that in Britain. (It should be stressed, however, that prior to legal control of narcotics, addiction was widespread in the United Kingdom.) Historical differences may have operated to help create, in America more than in Britain, the image of the drug addict as an underworld type. Very likely the detection and prevention of narcotics smuggling is much more of a problem in the United States than in the United Kingdom. And there may be other relevant differences between the situations in the two countries. But it does not necessarily follow from the fact that such differences may exist that the British approach will not work in America. When one considers the interrelationship between policy and problem, one can see that these differences may actually stem in large measure from the different policies in force in Britain and in the United States. One also becomes aware that current American policies cannot help but fail. The policy of withholding legal satisfaction of the demand for narcotics inevitably leads to a profit-motivated and socially-dangerous illicit market in drugs. There is no need to elaborate here on the evils of the current narcotics situation in the United States; the profiteer-

thing as a 'British System' which is an invention of certain Americans who wish to prove a particular point of view." "Advisory Committee to the Federal Bureau of Narcotics," *op. cit. supra* note 12. When the present writer inquired at the Home Office about such statements, an official pointed out that it is misleading to speak of a British "system" since that suggests a distinct plan decided upon and put into effect at a particular time. Actually the current "practice" or "approach" has evolved slowly through developing medical procedures and outlooks. Then too, the *laws* (in the narrow sense—including only statutes) in the United States and Britain *are* essentially the same. Both of these points are correct, strictly speaking, but they seem insufficient reason for creating the impression that American and British policies are the same. Very likely the desire to avoid publicizing any startlingly different approach to addiction stems in part from the avoidance of sensationalism which characterizes British drug policy generally. Also the writer has the impression that British officials are eager not to be put in a position where they seem to be criticizing their law enforcement colleagues in America. Unfortunately, this leads to implicit endorsement of an approach they would not accept in their own country.

[43] "British Narcotics System," *op. cit. supra* note 8, and adjoining text. Similarly, note the following statements attributed to a Narcotics Bureau representative at a recent New York City Youth Board conference: "Mr. Levine denounced 'lime-light-seekers, sensationalists and public speakers' who regard the addict as 'a poor, sick individual.' "

"He quoted excerpts from a book by Chief Magistrate Murtagh that he said were examples of 'false, vicious statements' being spread by 'pseudo-experts.' " N.Y. Times, Oct. 29, 1959.

[44] This resolution was instrumental in the closing of the clinics referred to in note 41, *supra*. Of the resolution, the Daniel Committee has stated: "The Bureau of Narcotics received a mandate from the medical profession to do what it has done, namely, suppress the clinics. This policy has never been withdrawn by the American Medical Association after its verbatim acceptance by the house of delegates in 1924. . . ." *Daniel Hearings, op. cit. supra* note 10, at 1459 n. 1. The resolution also is quoted with approval in the Narcotics Bureau's pamphlet for doctors, Prescribing and Dispensing of Narcotics Under Harrison Narcotic Law 8 (1956).

ing in contraband drugs, the high rate of addict criminality, and the special problems of juvenile addiction are well known. These problems are crucially *inter*related with our current policies. As Rufus King has stated, "It is precisely our law enforcement efforts, and nothing else, that keep the price of drugs, nearly worthless in themselves, so high as to attract an endless procession of criminal entrepreneurs to keep the traffic flowing."[45] It would seem foolhardy indeed to dismiss out of hand a policy which accords with common sense and humane feeling, and which has proven its effectiveness in Great Britain.[46] An experimental test of such an approach, as suggested by the AMA-ABA committee, seems the very least that can be done in the interests of uncovering a workable drug policy.

At the heart of the controversy over proposals for a more medically-oriented addiction policy in America lies the question: Should addiction be treated as a crime? The evidence from Britain suggests the considerable extent to which the addict's behavior is determined by the social reaction to his addiction. Keeping this in mind, it is difficult to see how addiction, as such, can properly be labelled a criminal form of behavior. Hermann Mannheim has suggested that only behavior which is anti-social should be treated as a crime.[47] The only real ground on which one could label addiction, as such, anti-social is that addicts tend to lead socially-unproductive lives. Even conceding this point, one would still have to ask whether addicts are *sufficiently* anti-social to be considered criminals. Above all it should be clear that addiction as such may not be as anti-social as are the types of addict behavior which a punitive approach to addiction tends to produce.

A last-ditch objection may assert that even if the addict is not overtly anti-social the preservation of certain basic social values requires anti-addiction laws. Thus one writer on addiction states: "It is morally indefensible for society to legalize a vice simply on the grounds that restrictive legislation creates an illicit market and hence a profit motive for racketeers."[48] It is difficult to reconcile the description of addiction as a "vice" with the generally accepted view (expressed even by Ausubel elsewhere in his book) that it is an illness. But probably there is no way of proving or disproving the claim that a type of human behavior is a "vice." The present writer, however, prefers to approach the problem of addiction not from a position based upon abstract moralizing, but rather from the standpoint of examining the specific social consequences of various addiction policies. If one proceeds along this latter path, the importance of the British experience becomes obvious.

[45] Rufus King, in *Daniel Hearings, op. cit. supra* note 10, at 1379.

[46] The writer has not intended to create the impression that the British policy is foolproof. Addicts occasionally succeed in getting extra drugs through forgery or by managing to get narcotics from two doctors at once. Some doctors abuse the system by diverting drugs to their own use. But all the evidence indicates that abuses are not widespread. It may also be worth noting that the British Government is far from complacent about the success of their drug policies. On the contrary, these policies are under almost constant review. For example, see the recent report, MINISTRY OF HEALTH, CENTRAL HEALTH SERVICES COUNCIL, REPORT OF THE JOINT SUB-COMMITTEE ON THE CONTROL OF DANGEROUS DRUGS AND POISONS IN HOSPITALS (1958). A review of the entire addiction question (by an expert committee established in 1958) has just been completed. The report is not yet available.

[47] MANNHEIM, CRIMINAL JUSTICE AND SOCIAL RECONSTRUCTION 5 (1946).

[48] AUSUBEL, *op. cit. supra* note 36, at 79.