



9-1-1964

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Recommended Citation

Robert B. Cash, *Narcotics Addiction: Civil Commitment and the Report of the President's Advisory Commission*, 39 Notre Dame L. Rev. 689 (1964).

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NARCOTICS ADDICTION: CIVIL COMMITMENT AND THE REPORT OF THE
PRESIDENT'S ADVISORY COMMISSION

Throughout the United States there has been mounting concern over the problem of drug addiction. Concern has been aroused by the substantial number¹ of persons afflicted with the disease,² and by the socio-economic exactions which addicts annually make upon society. Not only do addicts support the illicit traffic in narcotics which annually augments the profits of organized crime by millions of dollars,³ but they also cause staggering property losses. The average addict must spend between 20 and 50 dollars a day to satisfy his craving,⁴ so it often happens that he must turn to crime in order to procure the required funds. It has been estimated that the average addict must steal \$50,000 a year in order to support his habit.⁵ In New York City,⁶ the largest center of narcotic addiction, it is estimated that property losses attributable to addiction amount to about 200,000,000 dollars a year.⁷

In 1914, Congress passed the first federal law regulating narcotics.⁸ During the ensuing 50 years, legislators and doctors have done little more than prevent the spread of addiction.⁹ Narcotics, particularly heroin,¹⁰ continue to be smuggled into the United States with impunity,¹¹ while the cause and nature of addiction remain mysteries.¹² The failure to achieve a significant victory in the war against narcotics has occasioned a bitter dispute as to the wisdom of the present approach to the problem. A number of critics feel that low cost drugs should be made available to the addict as they are in England.¹³ They support their position by

1 Although the number of narcotic addicts in the United States is unknown, the number is probably between 45,000 and 50,000. PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 4 (Nov. 1963).

2 In 1962 the Supreme Court struck down a provision of the California law making addiction itself a crime. *Robinson v. California*, 370 U.S. 660 (1962).

3 The annual expenditure by addicts in this country for illicit narcotics is estimated to be \$219,000,000. HOUSE SUBCOMM. ON NARCOTICS, 84TH CONG., 2D SESS., REPORT ON THE ILLICIT TRAFFIC IN NARCOTICS 9 (Comm. Print 1956). The Federal Bureau of Narcotics estimated that one West Coast gang netted \$50,000,000 per year. OURSLER & SMITH, NARCOTICS: AMERICA'S PERIL 42 (1952).

4 Trasov, *Narcotic Dispensaries*, 2 CRIM. L. Q. 334, 335 (1960).

5 N.Y. Times, June 4, 1963, p. 16.

6 There are 22,000-50,000 addicts in New York City. Chicago and Los Angeles are respectively the second and third largest centers of addiction.

7 Kuh, *A Prosecutor's Thoughts Concerning Addiction*, 52 J. CRIM. L., C. & P.S. 321, 326 (1961).

8 INT. REV. CODE OF 1954, §§ 4701-36.

9 It is estimated that in the period beginning 1915-1922, the number of addicts decreased from approximately 215,000 to approximately 110,000. TERRY & PELLEN, *THE OPIUM PROBLEM* 3 (1928). The Federal Bureau of Narcotics estimated that in 1956 there were 60,000 addicts in the United States which purportedly represented a decrease of about 190,000 from the number existing prior to the passage of the Harrison Act in 1914, and a decrease from 1952, when the peak was reached in the post-war upsurge. HOUSE SUBCOMM. ON NARCOTICS, *supra* note 3, at 9.

10 Gelber, *Drug Addiction, The Addict and His Drugs*, American Journal of Nursing 53, 54 (July 1963).

11 The Treasury Department estimates that about 1½ tons of heroin are smuggled into the United States each year. Customs seizes less than 100 pounds a year. In 1962 and 1963, Customs seized 5 pounds and 35 pounds respectively. In 1962, the Bureau of Narcotics seized 164 pounds. PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 5 (Nov. 1963).

12 Freedman, *Action Research in a Treatment Center*, American Journal of Nursing 57 (July 1963).

13 See, e.g., Howe, *An Alternative Solution to the Narcotics Problem*, 22 LAW & CONTEMP. PROB. 132 (1957); Schur, *British Narcotic Policies*, 51 J. CRIM. L., C. & P.S. 619 (1960-1). Under the British system,

[M]orphine or heroin may be properly 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 with-

such arguments as: the Harrison Act is a failure; addiction is increasing; it is impossible to prevent the illegal importation of narcotics; the punitive approach is doomed to failure because of the enormous profits involved; and low cost drugs would remove the profit from the illegal trafficking in drugs. Those who oppose the English position feel that the English approach is not suitable for use in the United States because: England, unlike the United States, has never had a narcotics problem; dispensing narcotics would fail because addicts require increasing amounts of drugs which would still be supplied by the underworld; and the clinic approach has already been tried in the United States and has failed.¹⁴ "However, while warring camps and views heal each other with the soothing observation that drug addiction is indeed a baffling, complex, frustrating phenomenon, the narcotics addict continues his pursuit of drugs, oblivious to the conflict raging about him."¹⁵ It is the purpose of this article to show that recent enactments by the legislatures of New York and California and the Report of the President's Advisory Commission on Narcotic and Drug Abuse indicate that the problem of drug addiction is belatedly being approached in a fundamentally sound manner.

I. *The Addict*

A. Nature of Addiction

Relatively little is known about the nature of drug addiction. It is a highly complex disease — the result of a combination of factors: psychological; social; economic; ethnic; legal; physiological; metabolic; and possibly more.¹⁶ The prevention and cure of addiction will therefore require the combined labors of experts in many fields.

Addiction is characterized by a physical dependence upon drugs which necessitates the continued administration of the drug to allay the agony of withdrawal symptoms.¹⁷ A second characteristic of addiction is the phenomenon of tolerance; this is manifested in the need to continually increase the dosage of the drug in order to obtain as great an effect as was obtained on first administration. "[A]t the present time it is still acknowledged by experts that 'no experimentally verifiable concept has emerged clarifying the mechanism of tolerance or relating this to physical dependence of addiction.'¹⁸ Nor have authorities concluded that the continued use of opiates causes permanent changes in the brain or central nervous system, or any change except the body's greater tolerance of the drug.¹⁹ Evidence does exist, however, that the use of narcotics may cause the following detrimental factors:

1. Reduction or inhibition of internal controls and weakening of judgment.

drawal 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. Ostrow, *Drug Addiction: The Medico-Legal Conflict*, American Journal of Nursing 67, 70 (July 1963).

14 See, e.g., Trasov, *supra* note 4.

15 Ostrow, *Drug Addiction: The Medico-Legal Conflict*, American Journal of Nursing 67 (July 1963).

16 *Ibid.* See generally Clausen, *Social and Psychological Factors in Narcotic Addiction*, 22 LAW & CONTEMP. PROB. 34 (1957).

17 Withdrawal symptoms begin about six to eight hours after the last dose of heroin, and are characterized by yawning, perspiration, and lacrimation. The pupils of the eyes dilate, and "goose flesh" appears. These symptoms increase for approximately 24 hours, when the most severe symptoms begin: painful cramps in the legs, back, and abdomen; muscle tremors; labored breathing; increased pulse rate and blood pressure; vomiting; and diarrhea. Gelber, *supra* note 10, at 56.

18 Freedman, *supra* note 12, at 57.

19 Winick, *Narcotics Addiction and Its Treatment*, 22 LAW & CONTEMP. PROB. 9, 13 (1957). Another author states: "There . . . is no scientific evidence to support the claim that heroin has direct adverse physical effects except by inadvertent overdose." Trasov, *supra* note 14, at 336.

2. Impairment of [reliability] and constructive planning and promotion of rationalization.
3. Impairment of reproductivity.
4. Interference with normal earning capacity.
5. Reduction of response to normal stimuli.²⁰

One of the more puzzling aspects of addiction is the process of "maturing out." This refers to the fact that many addicts are able to "kick" the habit in their early thirties or forties with or without medical assistance.²¹ No precise physiological or psychological reason for this tendency is known.²²

[I]t has been suggested that since the anxieties related to those primary drives referred to earlier — sex, hunger, and aggression — diminish with age, the defense against the anxiety is no longer so necessary. There is also the possibility that the harried, driven life of theft and jail sentences becomes less tolerable with age.²³

This explanation is indirectly supported by the many authorities who feel that the withdrawal process, that is, the physiological aspect, is the least important step in the treatment of addiction.²⁴ Psychiatrists have shown that disturbances of personality are readily detected in persons who have become addicted to narcotics.²⁵ Such disturbances are thought to precede and predispose the addict to the use of drugs rather than result from their use.²⁶ Addiction, then, might not even be a sickness, but merely a symptom of a psychiatric disorder.²⁷ If so, the extremely high rate of relapse following withdrawal would be evidence of failure in curing the underlying psychological disorders.²⁸

B. Treatment of the Addict

Programs for the treatment of narcotic addicts have encountered the most discouraging of all obstacles — failure. Even the United States hospitals at Lexington, Kentucky, and Fort Worth, Texas, established specifically for the treatment of addicts, have enjoyed no appreciable success in their attempt to cure the addict.²⁹ A follow-up study of patients discharged from Riverside Hospital in New York established that out of a group of 147 patients who could be located two years after their release, 91 per cent had returned to the daily use of drugs while only 24 per cent had managed at least a six-month period in the community without drugs.³⁰ Repeated relapse, however, should not be the sole criterion of the success or failure of a treatment program.³¹ "People can and do stop using narcotics.

20 Trasov, *supra* note 19, at 337.

21 A study of 453 addicts released from the United States Hospital at Lexington indicated that addicts over 30 years of age show a significantly higher abstinence rate and a greater ability to abstain than those under 30, and that the ability to voluntarily give up drugs steadily improved as the subjects grew older. Freedman, *supra* note 12, at 60.

22 PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 22 (Nov. 1963).

23 Freedman, *supra* note 12, at 60.

24 Ludwig & Elsom, *Medical Correlation Clinics No. XII: Drug Addiction*, AMERICAN PRACTITIONER 865, 877 (Dec. 1961); Vogel, Isbell & Chapman, *Present Status of Narcotic Addiction*, 138 A.M.A.J. 1025, 1026 (1948).

25 Ludwig & Elsom, *supra* note 24, at 874.

26 PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 87 (Nov. 1963).

27 *Ibid.*

28 *Ibid.*

29 Cantor, *The Criminal Law and the Narcotics Problem*, 51 J. CRIM. L., C. & P.S. 521, 524 (1960-1).

30 Freedman, *supra* note 12, at 58. Riverside Hospital, after ten years of experimentation with the treatment of young addicts, is now closed. Murtagh, *Dilemma for Drug Addicts*, AMERICA 740, 742 (May 25, 1963).

31 It may take several hospitalizations before an addict develops sufficient strength to help himself for any appreciable length of time. Often the patient who has sought admission will feel "cured" as soon as his initial withdrawal distress has subsided. Convincing him that he should remain longer may require the persuasive powers of many doctors, nurses, administrator and family. A patient who "signs out" against advice should not be dismissed

They can lead normal lives. Neither individuals nor families need despair, although realism dictates that they prepare themselves for a disease of eight to fifteen years' duration."³²

The treatment of the narcotics addict is generally divided into three phases.³³ The first phase involves the admission of the addict to the treatment center and the achievement of complete abstinence from the addicting drug. Withdrawal is generally achieved by the use of methadone hydrochloride which serves as a substitute for the drug to which the patient is addicted.³⁴ Methadone is given in decreasing quantities in order to minimize withdrawal symptoms. Withdrawal is now almost routine, and is accomplished within seven to fourteen days, depending upon the level of the patient's habit at the time of his admission.³⁵

As soon as the patient has been withdrawn from drugs, the rehabilitative phase of the treatment begins. The patient's physical need for drugs has been cured, but his emotional dependence upon them remains. It is now the task of the psychotherapist to assist the patient in recovering from the psychological causes of his addiction. It is at this stage of treatment that the weakness of the federal program appears. At the Lexington Hospital, for example, two-thirds of the patients attend voluntarily; hospitalization is mandatory only if the patient has been imprisoned for violating the federal laws or if he has received a suspended sentence conditioned upon his submission to treatment. "[O]nly twenty-five per cent of these voluntary patients stay for the recommended minimum period of four and one-half months."³⁶

The third phase of the treatment begins when the patient leaves the institution which has treated him. "Follow-up care is vital to the lasting success of hospital treatment. The lack of supportive services is usually the reason some of the best intentioned addicts return to their dependence on drugs."³⁷ When the addict leaves the hospital, he is encouraged to attend a mental hygiene clinic and join a social club of discharged patients, such as Narcotics Anonymous, which will assist him in returning to the community.

II. Narcotics Legislation

A. Federal

The first significant step to curtail narcotics' addiction in the United States was the enactment of the Harrison Act³⁸ in 1914; this act was intended to halt the illicit traffic in narcotics through the imposition of a tax "upon narcotic drugs, produced in or imported into the United States, and sold, or removed for consumption or sale. . . ."³⁹ The act makes it unlawful for any person to purchase, sell, dispense, or distribute narcotic drugs⁴⁰ except in or from the original stamped

as hopeless but encouraged to seek readmission. Vandow & Knapp, *New York Hospitals Join Addiction Fight*, *The Modern Hospital* 115, 116 (Nov. 1963).

32 Rev. Norman Eddy, *American Journal of Nursing* 68 (July 1963).

33 See generally Anslinger, *The Treatment of Drug Addiction*, 14 *FOOD DRUG COSM.L.J.* 241 (1959); Winick, *supra* note 19.

34 Rohde, *The Addict as an Inpatient*, *American Journal of Nursing* 61, 63 (July 1963).

35 If the patient is addicted to barbiturates, however, the detoxification process is slower and much more dangerous. The patient remains on a stationary dosage for three or four days, and when the dosage is finally reduced, it is done in small quantities. During his withdrawal, the patient must be closely watched for convulsions, for a sudden reduction in dosage could be fatal. Rohde, *supra* note 34, at 63.

36 Winick, *supra* note 19, at 23.

37 Vandow & Knapp, *supra* note 31, at 116.

38 INT. REV. CODE OF 1954, §§ 4701-36.

39 INT. REV. CODE OF 1954, § 4701. Some pharmaceutical preparations are excepted under § 4702 if they have no addictive quality or minor addictive quality and the preparation does not permit recovery of the narcotic drug with such relative technical simplicity and degree of yield as to create a risk of improper use.

40 "Narcotic drugs" means any of the following, however produced:

(1) Opium isonipecaine, coca leaves, and opiate;

package; and the absence of the appropriate tax stamps is prima facie evidence of a violation of the act by the person in whose possession the package is found.⁴¹ Section 4722 requires every importer, manufacturer, producer, physician, dentist or other person who dispenses, distributes, or gives away narcotics to register; and whenever any person sells, barter, exchanges, or gives away narcotic drugs, he must use a special order form.⁴² The present penalties for violating the Harrison Act are: a minimum sentence of two years for a first offense of possessing narcotics; a minimum of five years for a second offense; and a minimum of ten years for a third offense. One who is convicted of selling, smuggling, or otherwise illegally transferring narcotics must be sentenced to a minimum of five or ten years respectively for a first and second offense.⁴³

Although the Harrison Act specifically exempts physicians from the provisions of the act relating to the use of special order forms⁴⁴ and the provisions relating to the original stamped package,⁴⁵ these exemptions apply only to a prescription issued to a patient in the course of his professional practice for legitimate medical purposes.⁴⁶ With its decisions in three cases, the Supreme Court effectively forced the doctor to abandon the addict. The first of these cases involved a physician named Webb who customarily gave prescriptions for morphine to habitual users upon their request.⁴⁷ He gave these prescriptions without considering the applicant's individual case, and in such quantities as the applicant desired, the only requirement being a slight charge of fifty cents for each prescription. In sustaining Webb's conviction the Court limited the "physician's prescription" exemption of the act; the defendant physician's purpose in granting the prescription was not to cure the patient but merely to provide him with drugs sufficient to keep him comfortable by maintaining his customary use. "To call such an order . . . a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required."⁴⁸

The second case involved a doctor whose regular practice was to write prescriptions for morphine for one dollar per gram.⁴⁹ Not only did he issue hundreds of prescriptions each month, but the prescriptions were for large quantities of morphine. In sustaining his conviction, the Court stated:

Manifestly the phrases "to a patient" and "in the course of his professional practice only" are intended to confine the immunity of a registered physician, in dispensing the narcotic drugs mentioned in the act, strictly within the appropriate bounds of a physician's professional practice, and not to extend it to include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of drugs.⁵⁰

The denouement of the doctor-patient relationship came two years later.⁵¹ Dr. Behrman gave a person known by him to be an addict, three prescriptions which enabled the addict to procure 150 grains of heroin, 360 grains of morphine, and 210 grains of cocaine. The ordinary dose of heroin was stated to be one-

(2) Any compound, manufacture, salt, derivative, or preparation of opium, isonipeaine, coca leaves, or opiate;

(3) Any substance (and any compound . . . derivative or preparation thereof) which is clinically identical with any of the substances referred to in clauses (1) and (2); . . . INT. REV. CODE OF 1954, § 4731.

41 INT. REV. CODE OF 1954, § 4704.

42 INT. REV. CODE OF 1954, § 4705.

43 INT. REV. CODE OF 1954, § 7237. This section also provides a sentence of not less than ten nor more than forty years for a person who is over the age of 18 and sells narcotics to one who is under the age of 18.

44 INT. REV. CODE OF 1954, § 4705(c).

45 INT. REV. CODE OF 1954, § 4704(b).

46 INT. REV. CODE OF 1954, § 4704(b)(2), § 4705(c)(2).

47 *Webb v. United States*, 249 U.S. 96 (1919).

48 *Id.* at 99.

49 *Jin Fuey Moy v. United States*, 254 U.S. 189 (1920).

50 *Id.* at 194.

51 *United States v. Behrman*, 258 U.S. 280 (1922).

sixteenth to one-eighth of a grain, for morphine one-fifth of a grain, and for cocaine one-eighth to one-fourth of a grain. The importance of the case lies in the fact that the government's indictment failed to allege bad faith on the part of Dr. Behrman. When the Supreme Court reversed the district court's dismissal, it effectually held that the prescribing of narcotics to a known addict was a violation of the Harrison Act regardless of the doctor's good faith or intent. Although the Supreme Court later retracted this blatant pronouncement in *Linder v. United States*,⁵² the damage was done. To the present day, the regulations of the Bureau of Narcotics cling to the discredited language of *Webb*:

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 section 4705(c) (2), and the person filling such an order, as well as the person issuing it shall be subject to the penalties. . . .⁵³

Although the Harrison Act continues to be the cornerstone of federal law, it was followed by four other acts. In 1922, Congress enacted the Narcotic Drugs Import and Export Act⁵⁴ which makes it unlawful to import any narcotic drug into the United States or territory under its control or jurisdiction unless the Commissioner of Narcotics determines that such importation is necessary in order to provide for medical and legitimate purposes.⁵⁵ The act bans the importation of crude opium for the purpose of manufacturing heroin,⁵⁶ restricts the importation of coca leaves⁵⁷ and marihuana,⁵⁸ and regulates the exportation of narcotic drugs.⁵⁹

The third federal law, the Marihuana Tax Act⁶⁰ was passed in 1937. Patterned after the Harrison Act, it requires that all persons who import, manufacture, sell, or otherwise distribute marihuana must register with the Secretary of the Treasury and that all transfers of marihuana be made on special forms. Basically it is a taxing act, placing a tax of one dollar per ounce on all transfers of marihuana if the transferee is registered, and a prohibitory tax of one hundred dollars per ounce if the transferee is not registered.⁶¹

One of the more curious laws regulating narcotics is the Opium Poppy Control Act⁶² of 1942. This act makes it unlawful for any person who is not licensed to produce⁶³ the opium poppy or to manufacture opium or opium products to: acquire the opium poppy or give or transfer the opium poppy to any person not so licensed; to send, ship, or deliver any opium poppies in the United States or its territories or possessions, except a carrier pursuant to an agreement with a duly licensed person; or to purchase or otherwise obtain opium poppy seed for the purpose of opium production. To date, no license has been issued pursuant to this act.⁶⁴

52 268 U.S. 5 (1925). At page 18 the Court stated:

[W]e cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.

53 26 C.F.R. § 151.392 (1961).

54 42 Stat. 596 (1922), 21 U.S.C. §§ 171-85 (1952).

55 42 Stat. 596 (1922), 21 U.S.C. § 173 (1952).

56 42 Stat. 596 (1922), 21 U.S.C. § 173 (1952).

57 42 Stat. 596 (1922), 21 U.S.C. § 173(a) (1952).

58 42 Stat. 596 (1922), 21 U.S.C. § 176(a) (1952).

59 42 Stat. 596 (1922), 21 U.S.C. § 182 (1952).

60 INT. REV. CODE OF 1954, §§ 4741-86.

61 INT. REV. CODE OF 1954, § 4741.

62 56 Stat. 1045 (1942), 21 U.S.C. §§ 188-188n (1952).

63 "Produce" includes planting, cultivation, growth, harvesting, and any other activity which facilitates the growth of the opium poppy. 56 Stat. 1045 (1942), 21 U.S.C. § 188a (1952).

64 PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 32 (Nov. 1963).

The final act of Congress, The Narcotics Manufacturing Act of 1960⁶⁵ authorizes the Secretary of the Treasury to license all manufacturers of narcotics and to limit the production of natural and synthetic narcotics.

B. State

With slight variations, forty-seven states, Puerto Rico, and the Virgin Islands have adopted the *Uniform Narcotic Drug Act*.⁶⁶ Three states—California, Pennsylvania, and New Hampshire—have their own acts. The essential sections of the Uniform Act are:

Section 1 defines narcotic drugs as coca leaves, opium, cannabis, and every other substance neither chemically nor physically distinguishable from them, and any other drugs, the importation, exportation or possession of which is prohibited, regulated or limited under the Federal Narcotic Laws, as existent on the date applied.

Section 2 makes it unlawful for any person to manufacture, possess, have under his control, sell, prescribe, administer, dispense, or compound any narcotic drug, except as authorized by the act.

Section 5 makes possession of or control of narcotic drugs lawful only if obtained in the regular course of business, occupation, profession, employment, or duty of the possessor.

Section 7 permits a physician or dentist to prescribe, administer, and dispense narcotic drugs in good faith and in the course of his professional practice only.

Section 10 states that a person is authorized to possess narcotic drugs in good faith and in the course of his professional practice only, except for Sec. 11.

Section 11 authorizes one to possess narcotic drugs if he is one to whom or for whose use any narcotic drug has been prescribed, sold, or dispensed by a person so authorized under Section 5.

Section 12 exempts certain persons from the provisions of the act restricting possession and control, such as common carriers or those who have only temporary incidental possession for the benefit of one who is lawfully entitled to possession.

The penalty provisions of the act were purposely left blank in order to permit the individual states to insert their own penalties. It is in this area that the greatest diversity exists between the several states.

The law of two states deserves special consideration because of the enlightened treatment they now give the narcotics problem. Recent legislation in California and New York provides civil commitment for addicts. Under these programs, the addict or potential addict is subjected to the authority of the state not only for the duration of his commitment in a treatment center, but even after his return to the community, when he is under the supervision of a parole or probation officer.

California. After providing for the establishment and operation of treatment facilities by the Department of Corrections,⁶⁷ the California legislation distinguishes between three classes of persons who may be subjected to commitment:

1. Addicts convicted of a crime,⁶⁸ except certain enumerated crimes,⁶⁹ and
2. Addicts convicted of misdemeanors;⁷⁰ and
3. Persons who are either addicts or in imminent danger of becoming addicts.⁷¹

The law provides that if after conviction of a crime in a municipal or justice court it appears that the defendant is a narcotic addict, the court must certify the defendant to the superior court which must then determine whether or not he is an addict or is in imminent danger of becoming one.⁷² If the defendant is found to be an addict or in imminent danger of becoming an addict, he is then

65 55 Stat. 55 (1960), 21 U.S.C. §§ 501-17 (1952).

66 9B UNIFORM LAWS ANN. 274.

67 CAL. PEN. CODE § 6400.

68 CAL. PEN. CODE §§ 6450-1.

69 CAL. PEN. CODE § 6452.

70 CAL. PEN. CODE § 6450.

71 CAL. PEN. CODE § 6500.

72 CAL. PEN. CODE §§ 6450-1.

committed to the custody of the Director of Corrections for commitment in a treatment center until such time as he is discharged pursuant to the act.⁷³ After the addict or potential addict has been confined for a minimum period of six months and has also recovered from his addiction or danger of addiction, he is eligible for release in an outpatient status,⁷⁴ and if released, he is kept under close supervision by specialized persons. Such supervision must include periodic and surprise testing for narcotic use, counseling, and return to inpatient status in the event that it would be beneficial.⁷⁵ If the addict abstains from the use of narcotics for three consecutive years after beginning outpatient status, the criminal charges against him may be dismissed.⁷⁶

Civil commitment is also provided for persons who are not charged with crimes or misdemeanors. If any person reports to the district attorney that he is an addict or is in imminent danger of becoming an addict, or is so reported by another person, the district attorney can petition the superior court to have the person committed to the treatment center.⁷⁷ If the superior court finds the person to be an addict or in imminent danger of becoming an addict, it must commit him to the treatment center.⁷⁸

New York. The New York commitment legislation is similar to that of California, providing both inpatient and outpatient care under close supervision.⁷⁹ After lodging the responsibility of establishing and operating treatment facilities in the Commissioner of Mental Hygiene,⁸⁰ the law distinguishes between three classes of persons who may be committed. The process and duration of commitment differ with respect to each class.

1. Addicts who voluntarily commit themselves or, if they are under 21 years of age, who are committed by their next of kin;⁸¹
2. Addicts who have been arrested for violating the narcotic law or for other crimes,⁸² except in certain cases;⁸³ and
3. Addicts who have been convicted of a crime.⁸⁴

In the case of an addict who voluntarily commits himself to a hospital or center providing treatment for addicts or is so committed by his next of kin, the law provides that he may be held for 45 days, and longer with the consent of the committing person.⁸⁵ In the event that the addict demands a judicial hearing, and is then found to be an addict, he may be committed to a treatment center for one year.⁸⁶ In either case, however, he may be discharged whenever he has recovered.⁸⁷

Addicts who have been arrested for violating narcotic or other criminal laws may request civil commitment at their arraignment, or within five days after arraignment with the court's permission.⁸⁸ The addict may thereupon be committed for a maximum of three years.⁸⁹ During this time the criminal charges against him are held in abeyance.⁹⁰ In the event that he successfully completes the treatment program before the expiration of three years, the criminal charges

73 CAL. PEN. CODE §§ 6450-1.

74 CAL. PEN. CODE § 6516.

75 CAL. PEN. CODE § 6517.

76 CAL. PEN. CODE § 6520.

77 CAL. PEN. CODE § 6500.

78 CAL. PEN. CODE § 6502. The length of commitment is 2½ years for persons committed upon their own request, and 7 years in other cases. CAL. PEN. CODE § 6521.

79 N.Y. MENTAL HYGIENE LAW § 207.

80 N.Y. MENTAL HYGIENE LAW § 204.

81 N.Y. MENTAL HYGIENE LAW § 205.

82 N.Y. MENTAL HYGIENE LAW §§ 211; 212.

83 N.Y. MENTAL HYGIENE LAW §§ 211(6); 212(6).

84 N.Y. MENTAL HYGIENE LAW § 206(9).

85 N.Y. MENTAL HYGIENE LAW § 205.

86 N.Y. MENTAL HYGIENE LAW § 206(2).

87 N.Y. MENTAL HYGIENE LAW §§ 205; 206(7).

88 N.Y. MENTAL HYGIENE LAW §§ 211(1); 212(2).

89 N.Y. MENTAL HYGIENE LAW § 213(3).

90 N.Y. MENTAL HYGIENE LAW § 210(2).

against him may be dismissed;⁹¹ but if he participates in the treatment program for three years, the charges against him must be dropped.⁹² Similar provisions are made for addicts who have been convicted of a crime, except that the period of commitment may be longer. Such an addict is generally placed on probation by the court on the condition that he submit to treatment. The jurisdiction of the Commissioner is then coextensive with the period of probation.⁹³ If the addict successfully completes the treatment program or is found to be unfit for treatment, he may be returned to the court which granted him probation.⁹⁴ In the event that the court should then sentence him to imprisonment, his sentence must be reduced by the amount of time spent as an inpatient under the treatment program.⁹⁵

III. Report of the President's Advisory Commission on Narcotic and Drug Abuse

In November of 1963, the President's Advisory Commission on Narcotic and Drug Abuse submitted its final report. The report is the result of ten months of labor, and represents the latest and most comprehensive investigation of the drug problem.⁹⁶ Although the focal point of the Commission's investigation was the narcotic and physically addicting drugs, it also investigated items ranging from tranquilizers to airplane glue. As used in the report, "drug addiction" includes both physical and psychological dependence, while "drug abuse" includes only psychological dependence. In order to combat drug addiction and abuse, the Commission made 25 specific recommendations, which may be summarized as follows.

A. Education

*The Commission recommends that a core of information and educational materials be prepared . . . to provide the public and all professions involved with accurate knowledge on narcotic and drug abuse to combat the misinformation that is so prevalent today.*⁹⁷

For many years the nature of drug addiction and the drug addict have been clouded by misconceptions and erroneous statements. After being told by a number of competent experts that many physicians, lawyers, social workers, and educators are uninformed about the problem, the Commission concluded that there is a critical need for an extensive and enlightened educational program. Such a program would be focused on the teen-ager who would be informed of the full range of harmful effects, both physical and psychological, that narcotic and dangerous drugs can produce. Although there is vigorous opposition to an educational program, the Commission states that it is their fundamental belief that "information rather than repression is the better avenue to follow."⁹⁸

B. Research

The Commission recommends that the Federal Council for Science and Technology, with the advice of an ad hoc committee of experts, design a comprehensive research plan covering all aspects of narcotic and drug abuse

91 N.Y. MENTAL HYGIENE LAW § 213(4).

92 N.Y. MENTAL HYGIENE LAW § 213(4).

93 N.Y. MENTAL HYGIENE LAW § 206(9).

94 N.Y. MENTAL HYGIENE LAW §§ 206(9); 213(5).

95 N.Y. MENTAL HYGIENE LAW § 213(6).

96 During the ten months, the Commission met regularly in Washington. It obtained the views of representatives of all the major federal agencies involved with drug abuse, and also held special meetings in New York City and Los Angeles. On these occasions it obtained the views of state and local officials, and visited private and public hospitals, research and rehabilitation centers, and correctional institutions. In addition, members of the Commission made individual visits to the various areas in the United States where drug abuse is of high incidence in order to study the particular problems of each locale and to inspect treatment and rehabilitation facilities. Finally, the Commission members participated in a number of conferences on drug abuse, and visited the Addiction Research Center and the United States Hospital at Lexington, as well as the borderlands between the United States and Mexico.

97 THE PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 19 (Nov. 1963).

98 *Id.* at 18.

*and that the National Institute of Mental Health earmark for narcotic and drug research a specific amount from its extramural research budget for each fiscal year to finance the operation of the plan.*⁹⁹

In stressing the need for research, the Commission emphasized the prevailing lack of knowledge in two particular areas of drug abuse: first, the lack of knowledge about the drug abuser and addict as a human being in the family and community; and second, the lack of knowledge concerning proper treatment procedures. What is the typical personality of the addict? To what extent does drug addiction and abuse have a psychological origin? It has been shown that addiction is most prevalent among the lower economic classes and among certain ethnic groups, particularly the Negro.¹⁰⁰ But if socio-economic pressures are important factors in causing abuse or addiction, why does one member of a family become an addict while his brother does not? In admitting that knowledge of proper treatment and rehabilitation procedures is sadly lacking, the Commission wonders whether the addict can ever be completely "cured." Will he ever be capable of leading a relatively stable and productive life? Might he not turn from property crimes to crimes against the person, or lapse into some serious form of mental disease? Because these and other questions remain unanswered, the Commission states that, "All present treatment and rehabilitation programs can only be considered as experimental."¹⁰¹

C. Treatment

*The Commission recommends that the federal government encourage and increase assistance to states and municipalities to develop and strengthen their own treatment programs and confine its activities in the immediate future to research instead of maintaining extensive public treatment programs.*¹⁰²

At present there is no accepted satisfactory course of treatment for drug addiction. Although the Commission feels that the "present lack of comprehensive technical knowledge makes it impossible at this time to make any definitive recommendations about treatment,"¹⁰³ it does feel that some general principles of treatment emerged from its study. First, the addict cannot be cured simply by withdrawal. He must be led by stages through a long and arduous process of treatment, including prolonged and extensive aftercare following withdrawal. Second, the services and facilities for the treatment and rehabilitation of the addict should be in or near his own community. Third, treatment and rehabilitation require an interdisciplinary approach. The psychiatrist, lawyer, penologist, teacher, criminologist, clergyman, and social worker may all make important contributions in the treatment program.

D. Control of Drug Traffic

*The Commission recommends that the functions of the Bureau of Narcotics relating to the investigation of the illicit manufacture, sale, other distribution, or possession of narcotic drugs and marihuana be transferred from the Department of the Treasury to the Department of Justice.*¹⁰⁴

⁹⁹ *Id.* at 24.

¹⁰⁰ Especially subject to narcotic addiction at this time are the Negroes. The Negroes are the most depressed group in the population, but that does not explain all the facts. For example, among Negro soldiers in the American Army in Japan — a group that is certainly well fed and well clothed — the incidence of narcotic addiction has been 30 times as great as in white soldiers in Japan. One wonders whether Negroes, for some racial reason, are especially subject to addiction. There are, however, plenty of addicts among white people, and in New York this is mostly seen among the Puerto Ricans who have arrived quite recently. Ludwig & Elsom, *Medical Correlation Clinics No. XII: Drug Addiction*, AMERICAN PRACTITIONER 865, 871 (Dec. 1961).

¹⁰¹ THE PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 23 (Nov. 1963).

¹⁰² *Id.* at 53.

¹⁰³ *Ibid.*

¹⁰⁴ *Id.* at 32.

The police work of the Bureau of Narcotics presently involves much the same set of relationships with state and local law enforcement agencies as that maintained by the Department of Justice. The Commission feels that transferring the investigative functions of the Bureau of Narcotics to the Department of Justice would not only facilitate narcotic crime detection, but would also assist the Justice Department in successfully prosecuting narcotic violators. Cases involving the large-scale, well-financed traffickers of drugs require long periods of preparation as well as complex questions of law. They involve questions of evidence, entrapment, search warrants, permissibility of arrest without a warrant, and the rights of the arrested person — all of which can best be handled by the Department of Justice.

*The Commission recommends a substantial increase in the number of federal enforcement personnel assigned to the investigation of and trafficking in narcotic drugs, marihuana, and dangerous drugs.*¹⁰⁵

Almost all of the illicit drug traffic in the United States is the result of smuggling. Of the estimated 1½ tons of heroin which is smuggled into the country yearly, Customs seizes but a few pounds. The Bureau of Customs presently provides inspection with only 729 investigators who are deployed among the various seaports and international airports, and along the Mexican and Canadian borders. The Bureau of Narcotics has only 297 enforcement agents, fourteen of whom are assigned to eight foreign countries, and whose task it is to combat smuggling at its source. In order to alleviate this forced dispersion of manpower and consequent loss of effectiveness, additional personnel should be furnished to both bureaus.

*The Commission recommends that the penalty provisions of the federal narcotics and marihuana laws which now prescribe mandatory minimum sentences and prohibit probation or parole be amended to fit the gravity of the particular offense so as to provide a greater incentive for rehabilitation.*¹⁰⁶

The Commission recommends that the present penalties of mandatory minimum sentence and prohibition of parole be retained for those persons who smuggle or sell large quantities of narcotics. The penalties should be relaxed, however, for those who smuggle, sell, or give away small quantities of narcotics. Such an offender should be subject to a fixed maximum sentence and denied a suspension of sentence, but should not be subjected to a mandatory minimum sentence and denied the hope of parole. The narcotic user who has no intention of selling the drug would be treated more leniently; he is merely the victim of his addiction. The courts should have complete discretion in handling him in order to facilitate his rehabilitation.

*The Commission recommends the enactment of legislation authorizing the use of wiretapping by federal law enforcement officials in limited circumstances and under strict controls to detect and prevent the international smuggling of narcotics.*¹⁰⁷

Although the Commission recognizes that the right to privacy in the individual is a sacred right in America and should only be invaded to meet the most serious threats to society, it believes that the illegal importation of narcotics into the United States is a threat of this magnitude. "Wiretapping would be strictly confined to the international smuggling of narcotics and hence would be used only in limited circumstances."¹⁰⁸ Only a judge of the United States district court could give permission to wiretap, and then only upon formal application of the Attorney General, or the Deputy Attorney General or Assistant Attorney General if expressly authorized by the Attorney General. The legislation permitting wiretapping "should forbid the disclosure of information gleaned by a federal investigative officer in the course of wiretapping except disclosures in the particular proceeding in which the order was issued,"¹⁰⁹ and should also "require that the extent of wiretapping

105 *Id.* at 39.

106 *Id.* at 41.

107 *Id.* at 46.

108 *Ibid.*

109 *Id.* at 47.

in cases involving the illegal importation of narcotic drugs be reported periodically for review of the operation of the statute."¹¹⁰

Conclusion

For 50 years the smuggler and addict have thwarted the efforts of the lawman and legislator. During these years, addicts have been supplied with illicit drugs while an endless stream of "criminals" has wound its way through various courts and jails. The failure to substantially reduce the number of addicts has occasioned a spirited dispute between those who would retain the present punitive approach to the narcotics problem and those who would dispense narcotics to the addict. If addiction is spread by the user, as is thought to be the case,¹¹¹ the distribution of narcotics would only increase the number of addicts. On the other hand, it is apparent that the present punitive approach has failed to substantially decrease the addict population. Perhaps the answer lies in a middle course.

The solution of the narcotics problem involves two fundamental concepts: treatment and prevention. Although there is no simple solution, the adoption of civil commitment legislation coupled with the adoption of the Commission's recommendations pertaining to the control of the illicit narcotic traffic offers a fundamentally sound approach to the problem. Civil commitment programs would provide the doctor with an invaluable opportunity for research — the opportunity to gain knowledge which is so sadly lacking. Given time, money, and the opportunity, medicine could certainly reduce the rate of relapse which presently follows withdrawal. If coupled with the Commission's recommendations for preventing addiction by consolidating the narcotic enforcement agencies and furnishing them with additional personnel, civil commitment would also play a preventive role. Consolidation of the investigative functions of the Treasury Department and the Bureau of Narcotics would increase efficiency, thereby increasing the number of arrests for violation of the narcotic laws; additional personnel in the Customs Department would decrease the amount of narcotics flowing into the country; while civil commitment programs would reduce the number of addicts purchasing narcotics, thereby reducing the profits of illicit narcotics. None of these could be decisive by itself, for all violators of the narcotic laws could never be apprehended; the illicit importation of narcotics could never be completely stopped; and all addicts could never be committed. Each of these suggestions, however, gains strength from the others. Together they could substantially reduce the attractiveness of the illicit drug business.

Robert B. Cash

110 *Ibid.*

111 In rebutting the view that new addicts are the result of peddler recruiting, the Council on Mental Health in its 1957 Report on Narcotic Addiction to the American Medical Association stated that:

The most careful, the most intensive, and the best controlled sociological studies available contradict this view, and state that association, curiosity, and so on, are far more important factors. If this is correct, it seems unlikely that furnishing drugs to addicts legally will stop the formation of new addicts. It might well enhance the spread of addiction, since the same social factors which presently are associated with addiction will continue to operate despite the source of the narcotics. Anslinger, *The Treatment of Drug Addiction*, 14 FOOD DRUG COSM. L.J. 241, 245 (1959).