The President's Advisory Commission on Narcotic and Drug Abuse

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The PRESIDENT'S ADVISORY COMMISSION on NARCOTIC AND DRUG ABUSE

FINAL REPORT • November 1963

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NOVEMBER 1, 1963.

DEAR MR. PRESIDENT:

Your Executive Order of January 15, 1963 asked this Commission to recommend a program "to prevent the abuse of narcotic and non-narcotic drugs and to provide appropriate rehabilitation for habitual drug misusers." You also requested the Commission to "review and evaluate the programs and operations of each federal agency which presently has law-enforcement functions or other statutory responsibilities directed toward the prevention of narcotic and drug abuse or the rehabilitation of habitual drug misusers" and to make recommendations "for improving the effectiveness of such programs and operations, including cooperation with and assistance to state and local governments by Federal agencies." The Commission now has the honor to submit to you its final report on these matters.

The Commission has met regularly in Washington throughout the year. It has obtained the views of representatives of all the major federal agencies involved with drug abuse, including ranking officials of the Department of the Treasury, the Department of Justice, the Department of State, and the Department of Health, Education, and Welfare. The Commission has also held special meetings in New York City and Los Angeles, cities in which drug abuse is particularly virulent. On these occasions the Commission obtained the views of state and local officials and experts, and it visited public and private hospitals, research centers, rehabilitation centers, and correctional institutions. These meetings and visits were an essential part of the Commission's deliberations.

In addition, members of the Commission or of the staff made individual visits to various areas in the United States in which drug abuse is of high incidence, to study the particular problems of each area and to inspect treatment and rehabilitation facilities. Southern California and areas of Mexico bordering the United States were visited to study the problem of drug smuggling. Visits were made to the Addiction Research Center and the United States Public Health Service hospital in Lexington, Kentucky. Commission members and staff participated in conferences on drug abuse sponsored by the University of California at Los Angeles, the University of Chicago Law School, the Middle Atlantic States Conference of Correction, Los Angeles State College, the Commonwealth of Massachusetts, the University of Michigan College of Pharmacy, and the International Narcotic Enforcement Officers Association. In addi-

tion, the Executive Director met with authorities in Great Britain and attended the 32d Session of the General Assembly of INTERPOL to confer with authorities from other countries.

Drug abuse has been of public concern in the United States throughout this century, and there is a vast amount of literature on the subject. The Commission has reviewed all the significant literature. It has also reviewed all the material presented at the first White House Conference on Narcotic and Drug Abuse, convened by you in Washington in September, 1962, and the report of the Ad Hoc Panel on Drug Abuse, convened by your Special Assistant for Science and Technology to prepare a background paper on the scientific and technical aspects of drug abuse for the White House Conference. The Commission has had the benefit of the written recommendations and views of a wide range of experts. Many of these views were solicited by the Commission in order to clarify particular problems.

On April 1, 1963, the Commission had the honor to submit to you its interim report, setting forth its tentative recommendations. The final report incorporates and supersedes the interim report. In addition, it presents many new recommendations. The members of the Commission concur unanimously in the final report.

Respectfully submitted.

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Chairman.
James P. Dixon.
James R. Dumpson.
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Austin MacCormick.
Rafael Sanchez-Ubeda.

INTRODUCTION

The concern and the distress of the American people over the national problem of drug abuse is expressed every day in the newspapers, the magazines, scientific journals, public forums and in the home. It is a serious and many faceted problem.

What are these drugs that can turn potentially useful citizens into hopeless, estranged, dependent individuals? That can turn normal young men and women to crime? They are many and include the natural and synthetic opiates such as morphine, heroin, dilaudid and demerol. They include cocaine, marihuana, LSD 25, mescaline, the barbiturates, the amphetamines, ether, airplane glue and even certain of the so-called "tranquilizers". All profoundly affect the central nervous system and the mind. The effects produced by taking these drugs are primarily on the brain and range from euphoria through excitement to depression. Some produce hallucinations. Many bring about a deep feeling that everything in life must be made to serve the purpose of maintaining a supply of the drug. These drugs are psychotoxic (mind poisoning). A psychotoxic drug is any chemical substance capable of adducing mental effects which lead to abnormal behavior. They affect or alter to a substantive extent, consciousness, the ability to think, critical judgment, motivation, psychomotor coordination, or sensory perception. Most of the psychotoxic drugs have a legitimate medical use. The opiates and their synthetic equivalents, the barbiturates, the "tranquilizers" and to a lesser degree the amphetamines, have a vital use in medicine when they are correctly prescribed. Abuse occurs when these drugs are used for their psychotoxic effects alone and not as therapeutic media prescribed in the course of medical treatment. Some psychotoxic drugs, marihuana is an example, have no practical medical use and any use of such drugs is an abuse. Patterns of drug abuse vary. A single drug may be abused continually or several drugs may be abused in combination or in rotation. The abuse of some psychotoxic drugs leads to a psychological dependence upon them. The abuse of others leads to true addiction, with physical as well as psychological dependence, tolerance, and certain characteristic physical symptoms following withdrawal from the drug. Cocaine, marihuana and the amphetamines are among the drugs that create psychological dependence, but not physical, while the opiates, the barbiturates, and even meproba-

mate, a tranquilizer, create both. In general, only the drugs that cause physical dependence with an acute physical distress on withdrawal and a need for ever larger doses in order to prevent withdrawal distress, and psychological dependence, with an overpowering compulsion to continue taking the drug, are considered to be truly addictive drugs. But addiction and the addicting drugs are only a part of the much greater problem of drug abuse which includes all of those psychotoxic drugs that produce psychological but not physical dependence.

When this report speaks of "drug addiction" it is using the term in its full technical sense to include both the psychological and the physical dependence. When it speaks of "drug abuse" it is referring to the broader problem which includes also those drugs which create only psychological dependency. We will use the term "drug abuse" in this report as existing when an individual takes psychotoxic drugs under any of the following circumstances:

(a) in amounts sufficient to create a hazard to his own health or to the safety of the community; or
(b) when he obtains drugs through illicit channels; or
(c) when he takes drugs on his own initiative rather than on the basis of professional advice.

Drug abuse today involves not only the narcotic drugs and marihuana, but to an increasingly alarming extent other drugs such as the barbiturates, the amphetamines and even certain of the "tranquilizers". This latter group will be referred to in this report as the "dangerous drugs".

Basic Philosophy

The abuse of drugs has aroused two extreme attitudes—the punitive and the permissive.

Some people are concerned primarily with the effects of drug abuse on the community. They know that it can debilitate and destroy the inner fabric of a man, and that if it leads to addiction, the abuser becomes obsessed with his drug, living for nothing else. They also know that drug abusers usually commit crimes against property because of their habit. They know that drug abuse is primarily spread by the drug abuser who persuades others to try the drug. Though they may not always consider drug abuse a crime,* this school takes an essentially punitive approach. Because most serious drug abusers return to drugs if left to themselves, these people would shut the drug abuser away from society for as long as possible.

*In 1962, the United States Supreme Court held a California statute which made the state of being addicted to narcotics a criminal offense unconstitutional under the Eighth Amendment, as a cruel and unusual punishment. *Robinson* v. *California*, 370 U.S. 660. Addiction has never been a crime under Federal Law.

In contrast to this attitude, others hold that serious drug abuse is usually symptomatic of a mental disturbance and that the drug abuser is a sick person. They attribute his crimes to an inner compulsion for which he should not be held responsible under our code of criminal justice. They feel that the drug abuser must be treated for his sickness rather than punished. Some feel his disease is incurable and that he should be maintained on the drug.

This Commission does not accept either of these extreme attitudes, but it subscribes to certain aspects of each. Rehabilitation is the humanitarian ideal, to be sought wherever possible. But rehabilitation is not simple. It requires the skills of many disciplines and the efforts of many agencies. The drug abuser who steals or who sells drugs to finance his habit is guilty of a crime. Like any other citizen, he should face the consequences. Whether he can be held criminally responsible can only be decided in the courts, case by case. The Commission cannot assert a general rule that every confirmed drug abuser is so impelled by his habit that he is not accountable for his acts under criminal law.

If the abuser is to be penalized, he should not be penalized in the spirit of retribution. The modern concept of criminology should apply—that penalties fit offenders as well as offenses. Penalties should be designed to permit the offender's rehabilitation wherever possible. Although society must often be protected from the offender for a time, penalties in specific cases should recognize the need for reformation.

The deterrent effect of long sentences is vigorously debated. Some evidence indicates that the threat of long sentences may deter non-using traffickers, but it does not necessarily deter the drug abuser. Deterrence is essentially an appeal to a normal sense of reason which the drug abuser has lost. The persistence of narcotic abuse, despite severe penalties for the possession of narcotics, is persuasive evidence that the abuser will risk a long sentence for his drug.

The general philosophy of this Commission can be stated in three parts:

(1) The illegal traffic in drugs should be attacked with the full power of the federal government. The price for participation in this traffic should be prohibitive. It should be made too dangerous to be attractive.

(2) The individual abuser should be rehabilitated. Every possible effort should be exerted by all governments—federal, state, and local—and by every community toward this end. Where necessary to protect society, this may have to be done at times against the abuser's will. Pertinent to all, the causes of drug abuse must be found and eradicated.

(3) Drug users who violate the law by small purchases or sales should be made to recognize what society demands of them. In these

instances, penalties should be applied according to the principles of our present code of justice. When the penalties involve imprisonment, however, the rehabilitation of the individual, rather than retributive punishment, should be the major objective.

Human and Social Consequences

Who becomes a drug abuser? Most known drug abusers in the United States are in the lower social and economic levels of our society. They are the frustrated, the hopeless, and the maladjusted. They fear or resent society and seek to escape from it and from its pressures. In large part they are concentrated in a few large metropolitan areas.

Some use drugs to seek relief from the tedium of their jobs and their lives. Some talented, even brilliant, individuals take to drugs to escape the fear of failure, or the knowledge that they have not fulfilled their potential. Some become "hooked" accidentally when they find themselves unable to give up the drug after undergoing medical treatment with one or more of these drugs to relieve pain. A larger number take to certain drugs to offset fatigue, and this group includes truckdrivers, theatrical people, and even doctors and nurses facing the letdown that follows long hours of tension. A very much larger group try psychotoxic drugs for "kicks", out of curiosity or bravado. They are usually juveniles who frequently find themselves unable to shake off the drug habit.

There is great ignorance of the patterns of drug abuse. The practice of drug addiction appears to be spread by the users themselves. The immediate physiological craving associated with withdrawal from narcotic drugs can now be alleviated by medical treatment. Because the original underlying psychological causes persist, however, the relapse rate following withdrawal from drugs is very high.

The existing information on drug abuse is pitifully inadequate. No one knows exactly how many drug abusers there really are in the United States. The number of narcotic addicts alone is estimated to be between 45,000 and 100,000. The total number of drug abusers would be much greater. It includes narcotics users who are not addicts and the many abusers of nonnarcotic drugs. The human toll cannot be measured, for it affects not only the abuser, but his family and the community around him. Drug abuse is closely bound up with juvenile delinquency. It also contributes to the rising crime rate in the United States. At the first White House Conference on Narcotic and Drug Abuse, Mayor Robert F. Wagner of New York City estimated that the number of narcotic addicts in that city might range as high as 50,000 and that they steal a minimum of half a billion dollars' worth of goods each year to finance their drug habits.

The illegal traffic in drugs is enormously profitable. Smuggling enterprises are well organized and well financed, and the ramifications

of the business are worldwide. Thus difficulties are involved; the drug traffic has not been ended. It has been estimated by the Department of the Treasury that about one and one-half tons of heroin are smuggled annually into this country. Customs seizures average less than one hundred pounds a year. The Bureau of Narcotics in 1962 seized 164.34 pounds.

Federal Responsibilities

The federal government has many responsibilities in the area of drug abuse. It has the primary power and therefore the basic responsibility with respect to foreign and interstate commerce. It should seek to check the illicit importation, manufacture, and transfer of narcotic and dangerous drugs. It should assist in the education of the public and of professional groups on drug abuse. It should ensure that these drugs are safe and efficacious and that they are used only for legitimate medical and scientific purposes. It should conduct extensive research on drug abuse and assist state and local governments and private organizations in conducting research. It should seek the rehabilitation of federal offenders who have a history of serious drug abuse and assist state and local governments and private agencies in their treatment programs.

The present activity of the federal government regarding drug abuse is fragmented. The divisions, agencies, and bureaus of five cabinet departments are involved. Inherent in this fragmentation is a lessened emphasis on the problem of drug abuse because other more important primary duties face each official. A strong, well-coordinated general policy for the operating divisions at lower levels has not been developed.

While drug abuse is not a federal problem of topmost priority, it should be given greater recognition because of its direct and damaging effects on our society. The increasing availability of psychotoxic drugs is partly due to failures in law enforcement—a vital concern of the federal government.

The individual abuse of the psychotoxic drugs and small-scale peddling are primarily state and local problems. Some states, cities, and private organizations have programs under way attempting to meet the problems of drug abuse, and in such instances the federal government's function should be one of guidance and assistance. From guidance and assistance for such programs to the active prosecution of its responsibilities with respect to drug traffic, from treatment of federal prisoners to the planning and support of research and stimulation of pilot projects, the federal government is already involved to some extent. Its leadership is needed even more.

This report is concerned with what the federal government can do to help reduce the tragic toll resulting from drug abuse.

PREVIEW OF RECOMMENDATIONS

1. The Commission recommends that the President issue a directive to all federal executives who can play a part in combatting the problem of narcotic and drug abuse to initiate immediately more aggressive action in the national interest. This recommendation is basic to all that follow.
2. The Commission recommends that the President appoint a Special Assistant for Narcotic and Drug Abuse from the White House staff to provide continuous advice and assistance in launching a coordinated attack. The Special Assistant will have general coordinating authority and the organizational responsibility to follow through on the evaluation and the implementation of the Commission's recommendations.
3. The Commission recommends that a citizens' advisory committee be created for service from time to time. This committee should be composed of authorities from all facets of drug abuse and be drawn from all relevant disciplines and professions. It should critically review progress made toward the development and execution of a federal policy and program. The Special Assistant would serve as liaison between the President and the advisory committee.
4. The Commission recommends that a core of information and educational materials be prepared by the Secretary of Health, Education, and Welfare 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.
5. 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 and that the National Institute of Mental Health earmark for narcotic and drug abuse research a specific amount from its extramural research budget for each fiscal year to finance the operation of the plan.
6. The Commission recommends that the Secretary of Health, Education, and Welfare establish a national reporting system to collect, collate, and analyze data on all forms of narcotic and drug abuse so as to obtain an accurate assessment of the problem. This should be set up on a cooperative basis with federal, state, municipal and private agencies participating.
7. The Commission recommends that the functions of the Bureau of Narcotics relating to the investigation of the illicit manufacture, sale, or other distribution, or possession of narcotic drugs and marihuana be transferred from the Department of the Treasury to the Department of Justice.

8. The Commission recommends that the responsibility for the investigation of the illicit traffic in dangerous drugs be transferred from the Department of Health, Education, and Welfare to the Department of Justice.
9. The Commission recommends that the functions of the Bureau of Narcotics relating to the regulation of the legitimate importation, exportation, manufacture, sale, and other transfer of narcotic drugs and marihuana be transferred from the Department of the Treasury to the Department of Health, Education, and Welfare. Narcotic drugs would be regulated under the power to regulate interstate and foreign commerce, not under the tax power; and the importation, production, sale, or other transfer of marihuana would be prohibited except where expressly licensed for legitimate scientific purposes or for the emergency production of hemp.
10. The Commission recommends that a unit be established within the Department of Health, Education, and Welfare to determine the safety and efficacy of and to regulate all narcotic and dangerous drugs capable of producing severe psychotoxic effects which can lead to criminal or lawless behavior when abused. This unit would also regulate the legitimate importation, exportation, manufacture, sale and other transfer of narcotic and dangerous drugs.
11. The Commission recommends a substantial increase in the number of federal enforcement personnel assigned to the investigation of the illicit importation of and trafficking in narcotic drugs, marihuana, and dangerous drugs.
12. 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.
13. The Commission recommends that all non-narcotic drugs capable of producing serious psychotoxic effects when abused be brought under strict control by federal statute.
14. The Commission recommends that the training school now conducted by the Bureau of Narcotics be more fully publicized among state and local law enforcement agencies, that in-service training sessions, workshops and seminars be conducted in the areas where drug abuse is most prevalent, and that the federal government provide field training courses for the dissemination of current federal information on narcotics control to state and local law enforcement officers.
15. 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.

16. The Commission recommends that the United States request the United Nations to establish a system of international control of the distribution of dangerous drugs. The Commission does not see the necessity of new federal legislation to supplement the general smuggling law by expressly prohibiting the illegal importation of dangerous drugs into the United States.
17. The Commission recommends that the United States invite the Mexican government to assist in the establishment of a Joint United States-Mexico Commission for consultation on the development of better methods to curb the illegal flow of narcotics, marihuana, and dangerous drugs between Mexico and the United States.
18. The Commission recommends that the United States oppose, in its present form, ratification of the Single Convention on Narcotic Drugs, 1961, until there is a correction of those sections which weaken the control and limitation of world opium cultivation and production as established in the Protocol of 1953.
19. 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.
20. The Commission recommends that federal regulations be amended to reflect the general principle that the definition of legitimate medical use of narcotic drugs and legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession.
21. The Commission recommends that legislation be designed to provide authority for the Federal government to render direct financial and technical assistance to state governments (singly or acting together on a regional basis), to local governments, and to private nonprofit organizations for the establishment, maintenance, and expansion of broad treatment and rehabilitation programs and the training of staff and personnel to staff and operate the programs.
22. The Commission recommends federal assistance to state governments, acting singly or on a regional basis, and to local governments for the construction of non-hospital treatment centers for narcotic and dangerous drug abusers and for new treatment units in existing state and local hospitals.
23. The Commission recommends that the Public Health Service hospitals in Lexington, Kentucky, and Fort Worth, Texas, accept voluntary patients only for purposes of research study in the future.

24. The Commission recommends that the Bureau of Prisons establish a special treatment program for confirmed narcotic and drug abusers within the federal prison system.
25. The Commission recommends that a Federal civil commitment statute be enacted to provide an alternative method of handling the federally convicted offender who is a confirmed narcotic or marihuana abuser.

EXHIBIT I

ADDICTING AND NONADDICTING DRUGS

I. Drugs Associated with Physical Dependence.

A. Opiate Type (central nervous system irritability and autonomic storm on withdrawal).

1. Morphine Group: Opium and its preparations (laudanum, paregoric, morphine, diacetylmorphine [heroin, illegal in the United States], codeine, dihydromorphinone [dilaudid], dihydrocodeine, dihydrocodeinone ["Hycodan"], dihydrohydroxycodeinone ["Percodan"], dihydrohydroxymorphinone ["Numorphan"].
2. Morphinan Group: Racemorphan ("Dromoran"), levorphan ("levo-dromoran").
3. Benzmorphans: Phenazocine.
4. Meperidine Group: Meperidine ("demerol," the physician addicts' favorite), alphaprodine ("Nisentil"), anileridine.
5. Methadone Group: Methadone.
   d-Propoxyphene ("Darvon") and diphenoxylate ("Lomotil") are so weakly addicting that they are not controlled by United States narcotic laws.
6. Dithienylbutenylamines.
7. Hexamethyleneimines.
8. Benzimidazoles.
   The narcotic antagonists, nalorphine ("Nalline") and levallorphan, are not addicting.

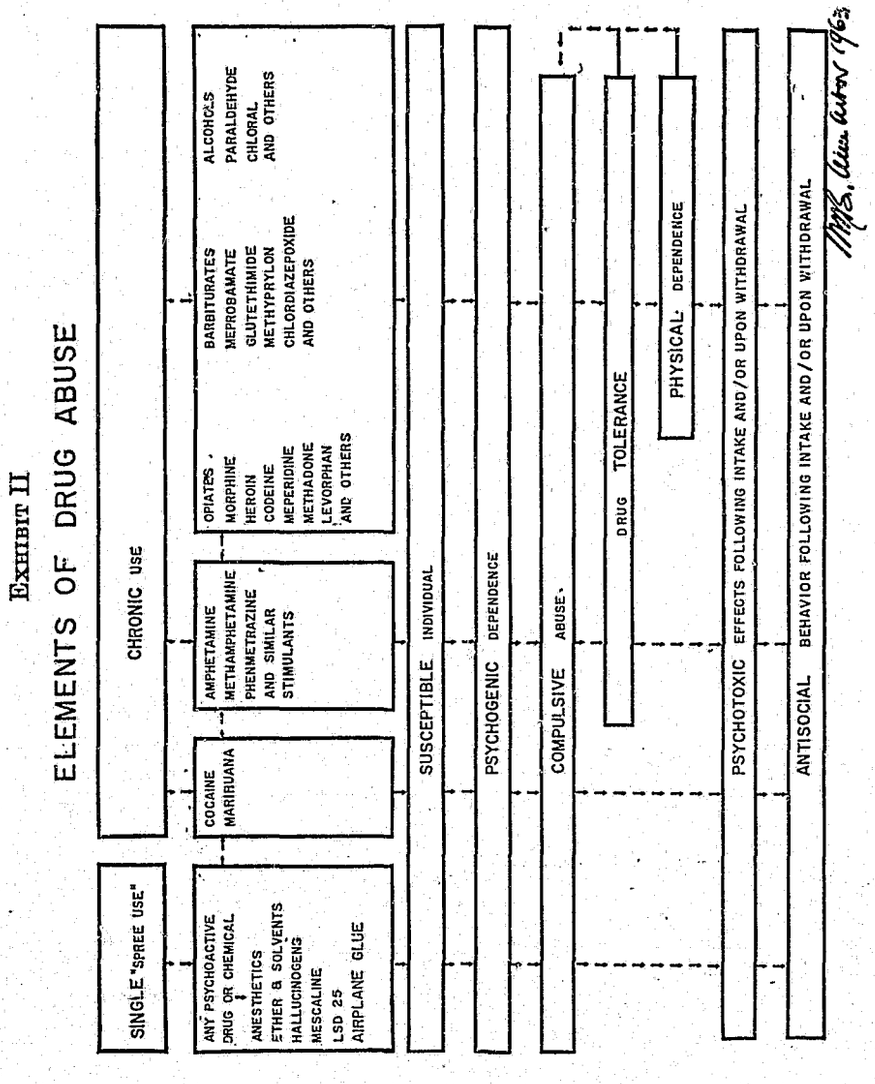
B. Barbiturate-Alcohol Type (convulsions and delirium on withdrawal).

1. Barbiturates: pentobarbital, secobarbital, amobarbital, cyclobarbital, phenobarbital, barbital, etc.
2. Ethyl alcohol: all forms.
3. Chloral hydrate.
4. Paraldehyde.
5. Meprobamate ("Miltown," "Equanil").
6. Glutethimide ("Doriden").
7. Methaminodiazepoxide ("Librium").

II. Drugs Not Associated with Physical Dependence.

1. Marihuana.
2. Cocaine.
3. Amphetamines: Amphetamine, Methamphetamine, dextroamphetamine, etc.
4. Hypnotics, sedatives and certain "tranquilizers": Bromides, reserpine and related alkaloids, chlorpromazine.

EXHIBIT II



I

A PRESIDENTIAL DIRECTIVE

Hundreds of suggestions and proposals have been made by well-qualified experts. But the traffic in drugs continues, and victims continue to drift because of unorganized, pitifully inadequate proffers of assistance. Well-intentioned efforts are being made in some sections of the country with respect to certain segments of the problem. There has never been a sustained, organized attack upon the entire problem.

The Commission recommends that the President issue a directive to all federal executives who can play a part in combatting the problem of narcotic and drug abuse to initiate immediately more aggressive action in the national interest. This recommendation is basic to all that follow.

The fact is that the drug abuse problem is enmeshed in conflicting authorities, each only partially concerned, and in emotional overtones of conflicting philosophies. Moreover, it is so embedded in historical anomalies, and is so effectively opposed by criminal elements, that no major improvement can be achieved without the preemptory requirement for action—rather than discussion—by the President.

This Commission is a temporary advisory body with no statutory authority to initiate action. Only when the authorized executives of the federal government take action, under the direction of the President, will the recommendations contained in this report yield results.

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II

THE COORDINATION OF A FEDERAL PROGRAM

There should be a system for coordinating all federal policies and programs. This Commission does not consider an interagency committee an effective means. A comprehensive federal program cannot be instituted overnight. Some new legislation will have to be enacted. In many instances, the attitudes and functions of federal bureaus and agencies must be profoundly altered. New or improved administrative programs will have to be planned in detail and put into operation, and new personnel found to staff them. Even after a comprehensive program has been instituted, it will have to be constantly shaped and formulated as new findings emerge.

The Commission recommends that the President appoint a Special Assistant for Narcotic and Drug Abuse from the White House staff to provide continuous advice and assistance in launching a coordinated attack. The Special Assistant will have general coordinating authority and the organizational responsibility to follow through on the evaluation and the implementation of the Commission's recommendations.

The Special Assistant would provide the President during the formative period with continuous information necessary for the development of a policy and program and to coordinate the activities of the agencies executing the policy and program. The Special Assistant should understand all the facets of drug abuse and their interrelationship: law enforcement; customs interception; the regulation of importation, manufacture, and distribution; research; treatment; and education. He should have a grasp of the problem in all its ramifications, including all new federal efforts which can contribute in any way to the fight against drug abuse—for example, programs to control juvenile delinquency, to prevent school dropouts, to gain youth employment, to provide vocational and remedial education, and to provide mental health services and facilities. Once a federal policy and program has been fully developed, the functions of the Special Assistant can be assumed by regular operational units. The position should not be set up on a long-term permanent basis.

The Commission recommends that a citizens' advisory committee be created for service from time to time. This committee

should be composed of authorities from all facets of drug abuse and be drawn from all relevant disciplines and professions. It should critically review progress made toward the development and execution of a federal policy and program. The Special Assistant would serve as liaison between the President and the advisory committee.

A federal policy and program cannot simply be formulated at the Presidential level and handed down to the federal departments for execution without constant cross-fertilization. The experience and ideas of the operating departments must be transmitted to the President for evaluation.

There exists an Interdepartmental Committee on Narcotics, established in 1951, consisting of the Attorney General and the Secretaries of State, Defense, the Treasury, and Health, Education, and Welfare. This Committee has met spasmodically since its inception. Its last report was on January 10, 1961—its first in five years. The Committee is apparently now moribund. The Special Assistant should consider revitalizing this Committee for such uses as might seem needed, including an exchange of ideas and the coordination of interdepartmental activities.

III

EDUCATION

The Need for Public and Professional Education

The Commission has received convincing evidence that a critical need exists for an extensive and enlightened educational effort on drug abuse. The problem is still clouded by misconceptions and misinformation about "the perils of dope" and the viciousness of "the fiend" and "the pusher." These distorted attitudes are not confined to the general public; many fallacies continue to persist in professional circles.

These persistent misbeliefs range all the way from the notion that a single dose of heroin can cause addiction to the equally erroneous notion that once a person becomes addicted to narcotics he is beyond all hope of rehabilitation. Some of the public misconceptions stem from newspapers and magazines which have emphasized the more lurid aspects of drug abuse. Others can be traced to the romanticized writings of Coleridge, De Quincey and Aldous Huxley on the effects of drugs.

In fact, the usual treatment accorded drug abuse in print has done little, if anything, to dispel the old misconceptions. There is, for example, scant recognition of the fact that drug abuse may reflect a profound personality disturbance—an individual's inability to cope with life. Nor has the public grasped the magnitude of the economic and social burden imposed by those who abuse drugs. Millions of dollars in property are stolen each day, and there are the additional costs of law enforcement and of health and welfare services.

Only through an enlightened educational campaign can the public become aware of the true nature of drug abuse and the burden it imposes on the nation. An educational program for professional personnel whose activities touch upon some aspect of this problem is likewise an urgent need. The Commission was repeatedly told by competent experts that physicians, lawyers, social workers, and educators are frequently uninformed about the problem. Moreover, instruction on drug abuse in professional schools is inadequate.

When the Commission speaks of the education of the teenager, it is addressing itself to prevention. An educational program focused on the teenager is the *sine qua non* of any program to solve the social problem of drug abuse. The teenager should be made conscious of

the full range of harmful effects, physical and psychological, that narcotic and dangerous drugs can produce. He should be made aware that although the use of a drug may be a temporary means of escape from the world about him, in the long run these drugs will destroy him and all that he aspires to. The education of the teenager is, therefore, an essential requisite of any prevention program.

There is a vigorous school of thought which opposes educating teenagers on the dangers of drug abuse. The argument runs that education on the dangers of drug abuse will only lead teenagers to experimentation and ultimately to addiction. The Commission rejects this view. Drug abuse is contagious in the social sense of the word, and most drug abusers are introduced to drugs by other users. The Commission feels that the real question is not whether the teenager should be educated, but who should educate him? Should it be the street corner addict, or should it be the schools, churches, and the community organizations? The opposing view runs counter to the basic theory of the American philosophy. Our fundamental belief is that information rather than repression is the better avenue to follow. Education is the best weapon in the long run.

The Federal Role in Education

The Federal Bureau of Narcotics and the National Institute of Mental Health are the two agencies of the federal government presently involved in the education of the general public and of professional groups on drug abuse.

The educational and information activities of the Bureau of Narcotics are limited. Bureau representatives lecture on the federal narcotics laws and regulation, and on the narcotics problem, to medical, dental, nursing, pharmacy, and veterinarian schools, and to some medical and nursing organizations. Their most frequent appearances are at pharmacy and nursing schools. In fiscal year 1963, Bureau representatives delivered 89 lectures to more than 80 schools and organizations. Until April of this year, they lectured only on request, but the present policy of the Bureau is to solicit opportunities to lecture. The Bureau has issued several pamphlets on narcotic drugs and marihuana. An example is the pamphlet entitled "Prevention and Control of Narcotic Addiction". It discusses the principal legal controls on these substances and sets forth the Bureau's views opposing administration of maintenance doses to addicts and favoring the imposition of heavy penalties on narcotics and marihuana offenders.

The National Institute of Mental Health (NIMH) is the primary source in the federal government of informational and educational materials on drug abuse. In October 1962, NIMH established the National Clearinghouse for Mental Health Information, which collects, stores, and disseminates to researchers abstracts of the professional literature and other information on drug abuse. The

Clearinghouse also assembles information on the various substantive aspects of drug abuse for physicians, social workers, educators, and other persons who, while not researchers, become professionally involved with practical aspects of drug abuse in their daily work.

NIMH has been active in the publication of monographs and other materials. In June 1963, it published an excellent monograph entitled "Narcotic Drug Addiction," a comprehensive overview of the subject intended for physicians, lawyers, social workers, and others who may work or come into contact with narcotic addicts. NIMH has recently revised and reissued a brochure entitled "Barbiturates as Addicting Drugs." In cooperation with its Addiction Research Center at Lexington, NIMH has published a series of bibliographies for professional persons. NIMH has begun to plan a brief, nontechnical pamphlet on drug abuse aimed specifically at reaching the high school student.

NIMH makes general grants to the states for preventive services in the field of mental health, and portions of these grants may be used to develop informational and educational materials on drug abuse. NIMH may also make grants to state, local, and private nonprofit agencies for demonstration projects looking exclusively to the development of informational and educational materials. In addition, many research projects on drug abuse financed by NIMH have components that look to the publication of such materials.

This Commission feels, however, that public and professional education on drug abuse is still inadequate. First, medical, nursing and pharmacy schools should strengthen their courses on the use of narcotic and dangerous drugs in legitimate medical practice and provide more adequate knowledge of the dangers involved in drug abuse. Second, the general public must be educated. All available media—newspapers, magazines, books, motion pictures, radio broadcasts and television showings—should be involved as a public service. Third, teenagers in schools in cities where drug abuse is of high incidence should be carefully and thoroughly educated concerning the dangers inherent in drug abuse.

> *The Commission recommends that a core of information and educational materials be prepared by the Secretary of Health, Education, and Welfare 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.*

The Commission believes that informational and educational materials should be developed by NIMH with the appropriate assistance and advice of other federal agencies, state and local agencies, universities, and private nonprofit organizations sharing a responsibility in this area. It should particularly seek the assistance and advice of the Office of Education in the Department of Health, Educa-

tion, and Welfare in the preparation of materials designed for each of the target groups involved. The materials should be aimed at many audiences—the parent, the teenager, the college student, the general adult public, the educator, the lawyer, the physician, the social worker, correctional personnel, the probation-parole officer and the members of civic service groups. The materials should extend from those suitable for publication in professional journals to materials designed for the mass media. They should range from books and articles to tapes and films.

The availability of such informational and educational materials should be well publicized. Informational material should be distributed to state and local agencies, professional societies, and private community organizations having an interest. The Commission believes the Department of Health, Education, and Welfare should use all of its resources to embark upon an aggressive, widesweeping information campaign directed by public relations professionals. The problem of publicizing the availability of materials is not for amateurs or laymen. Trained mass media experts should direct the effort.

The federal government in the last analysis can do no more than prepare a core of informational and educational materials on drug abuse. The decision to use these materials must rest with the states and municipalities, professional schools and societies, community organizations, and the individuals to whom they are offered. Nevertheless, it is clearly incumbent upon the federal government to develop and make available an aggressive, far-reaching information program covering all aspects of drug abuse.

IV

RESEARCH

The Prevailing Lack of Knowledge

The Commission has been deeply impressed by the report of the Ad Hoc Panel on Drug Abuse, prepared as a working paper for the first White House Conference on Narcotic and Drug Abuse. That report and the Conference highlighted the need for more extensive research and for a clearly defined federal policy to foster such research.

Basic knowledge is lacking about the causes of drug abuse. It may be triggered by curiosity, or a search "for kicks," or a desire to conform to a group pattern. A person may become addicted following prolonged use of a drug during legitimate medical treatment. The habit may stem from a sense of social inadequacy or be an escape from pressures and frustrations. It may reflect a deep-seated personality disturbance or the influence of cultural forces. How do these factors work? Which predominate?

The largest gap in our present knowledge has to do with the drug abuser as a human being in the family and community. Behavioral studies on psychological and social aspects of drug abuse have been few and scattered. What is the typical personality of the drug abuser? To what extent does drug abuse have a psychological origin? What is his family background and in what family structure does the drug abuser grow up?

If family background and economic and social pressures are important, why does one juvenile from a slum family become a drug abuser while his brothers do not? A study made in 1956 of juvenile male heroin users in New York City stated that "a certain set of symptoms appears to be common to most juvenile addicts. They are not able to enter prolonged, close, friendly relations with either peers or adults; they have difficulties in assuming a masculine role; and they are frequently overcome by a sense of futility, expectation of failure and general depression. They are easily frustrated and made anxious and they find both frustration and anxiety intolerable".* If personality is so crucial, why do some juveniles with this personality pattern become drug abusers while others do not?

*Chein, Isidor and Rosenfeld, Eva, "Juvenile Narcotics Use," Law and Contemporary Problems, Winter, 1957, XXII, 52–63.

In cities where drug abuse is most widespread, it predominates among certain ethnic groups. Yet ethnic origin does not appear to be a predisposing factor in itself. The predominant ethnic group that abuses drugs varies from city to city. For certain ethnic groups the abuse of drugs seems to be part of a much larger problem—a loss of identity with the prevailing group culture, an increased sense of isolation from society at large.

What unique and psychological needs does the subculture of the drug abuser fulfill? Is there a general acceptance of drug-taking among members of certain groups that makes the initial step to drug abuse easier than among members of other groups? Perhaps some of these questions can best be answered by studying the majority of slum-dwellers who successfully reject the lure of drugs.

There are other puzzling aspects of drug abuse. The incidence of narcotic addiction in the population declines rapidly as the individual nears age 40. Is there any physiological or psychological explanation for this? Or does it simply reflect the toll of death and long-term imprisonment? Why will a drug abuser who has abstained successfully for a long time relapse? Why is heroin the drug of choice among narcotic abusers when it does not produce addiction any more rapidly or provide any greater euphoric effect than morphine?

There is little reliable statistical information. Estimates of the number of narcotic addicts in the United States range from 45,000 to 100,000, and estimates of the number of addicts in the cities where they are concentrated also vary. How can an accurate epidemiology of addiction be said to exist in view of the disagreement regarding the number of existing addicts? Or if the breakdown by age and sex is unknown? The number of former addicts in the population who are presently off drugs has never been determined. Nor are there statistics on the rate of relapse, or on how many turn to narcotics each year for the first time. As for the abuse of dangerous drugs, almost nothing is known of its incidence or geographical distribution.

Much remains to be learned about the medical aspects of drug abuse. It is known that an individual will develop tolerance to certain psychotoxic drugs when they are habitually abused so that the dosage must be increased continually to produce the effects of the first dose. Beyond this generality, little is known. The basic physiological mechanism of tolerance needs full investigation. Individuals with normal personality and physical characteristics can become physically and psychologically dependent on some psychotoxic drugs when taken continuously over long periods of time. The biochemical and pathophysiological mechanisms of physical dependence need to be investigated. To what extent do abnormal physical factors (for example, an inherent metabolic deficiency) contribute to compulsive drug abuse? If they are found to contribute, is correction by chemical agents possible?

Non-addicting analgesics for medicinal uses should be developed, and there is hope that they may be. However, the number of persons addicted in the course of prolonged medical treatment represents only a small fraction of the nation's total addict population. New non-addicting drugs that can curb the desire for specific psychotoxic drugs are within the promise of research.

Though methods now exist to detect the presence and amount of psychotoxic drugs in the human body, each has some apparent drawback for widespread practical use. Improved ones must be sought. Manufacturers and the federal government must carefully evaluate new drugs to determine their psychotoxic liability.

Knowledge of proper treatment and rehabilitation procedures is sadly lacking. We know how to withdraw the addict from his drug. But detoxification is only the first small step. There is also need for physical conditioning, psychotherapy, vocational training, education, counseling, and recreational therapy. Close supervision of former addicts for a considerable time after their return to the community seems to be strongly indicated. But there is at present no fully established course of treatment because the basic research is lacking to provide guidelines as to what it should be. Since there is no agreement on a regimen of choice, it is important to proceed simultaneously with a broad range of treatment programs.

All present treatment and rehabilitation programs can only be considered as experimental. How best should a halfway house for the addict under treatment function to serve as a way station between the treatment center and his return to the community? After the rehabilitated drug abuser has returned to the community, what facilities should there be for continuing therapy, vocational training, and job placement? What specific role should the general physician play in treatment and rehabilitation? What functions should the psychiatrist, the social worker, the probation and parole officer fill? What is the most practical caseload for the social worker and the probation or parole officer when handling former drug abusers?

What is the ultimate fate of the treated addict? Can he ever maintain a relatively stable, moderately productive life? Or will he turn from crimes against property to crimes of violence? Will he lapse into serious forms of mental illness? What should be the definition of a "cure"? Can an addict ever be pronounced as "curable" or "incurable"? If pronounced "incurable," how should he be handled? Can an "incurable" addict who is maintained on stable doses of his drug lead a comparatively normal life?

Those who work closely with addicts recognize the important role of prevention in meeting the social dangers of drug addiction. How can addiction be prevented if a predisposition to abuse drugs cannot be identified early enough to treat accordingly? A classification of drug abuse by type, intensity and other characteristics

is needed. It would define the stages between early experimentation and actual addiction. In this way, the experimental drug abuser who is a potential addict could be identified and the necessary steps taken to prevent confirmed drug abuse.

Some other needed lines of research are: the physical effects of the abuse of psychotoxic drugs; the ways in which drug abuse is spread; the effects of penalties imposed on narcotic abusers; the practicalities of out-patient treatment; the effective methods of coping with the marihuana problem by way of prevention, legal control, treatment; the extent to which the marihuana problem should be considered as separate and distinct from narcotics; and investigation to determine if any relationship exists between alcoholism and the onset or cessation of drug abuse; as well as any underlying predisposition towards addiction to alcohol or drugs.

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

This recommendation is easy to make. Indeed, it has been repeatedly made. The Commission believes that needed research will never be obtained without such a plan. A comprehensive plan has never been attempted. But the design of such a plan is enormously difficult. It will require time, a comparatively modest budget, and the use of all pertinent knowledge. The Commission recommends that a directive be issued without delay to the Federal Council for Science and Technology—which includes the research heads of all federal departments and agencies—to form at the earliest date an ad hoc advisory committee for this purpose. This ad hoc committee should be drawn from authorities in all the disciplines concerned with drug abuse, within the federal government and outside.

This Commission does not venture to dictate the specific content of a Comprehensive Plan of Research. Certain areas that the Commission feels should not be overlooked have been indicated in the previous section. As to method, the Commission believes that:

1. The Plan should itemize and describe the subjects for research.
2. The Plan should assign priorities for research among the itemized subjects.
3. The Plan should estimate the cost of each itemized research subject.

4. The Plan should designate the federal agencies and bureaus to be assigned primary responsibility to ensure that the necessary research on each itemized subject is carried out.
5. The Plan should determine how existing federal resources not presently involved can best be included in the research effort. For example, the research role that may be assumed by the facilities and personnel of the Veterans Administration.
6. The Plan should describe in general the best method for accomplishing the necessary research, and whether it should be conducted by an agency of the federal government or outside, and if extramural, whether it should be financed by grant or contract.

In sum, a Comprehensive Plan of Research should pinpoint all the gaps existing in our knowledge of drug abuse. The Plan should lead to an intensive examination of the more important medical and social aspects of drug abuse. It should also consider the moral and spiritual values inherent in the problem. Since any successful attack depends on what research reveals, the Plan should be expedited as rapidly as possible.

The Department of Health, Education, and Welfare now conducts and sponsors research on drug abuse. The Food and Drug Administration within the Department studies methods for the detection, identification, and evaluation of new drugs.

The Vocational Rehabilitation Administration within the Department supports research seeking to develop new techniques to improve vocational rehabilitation services for the physically and mentally disabled. Drug abusers benefit from this research.

The National Institute of Mental Health (NIMH) of the Public Health Service is the prime research agency on drug abuse. The Public Health Service Act expressly authorizes the conduct and financing of research on mental health and on the care, treatment, and rehabilitation of the mentally ill. This authority extends to drug abuse, including drug addiction. NIMH conducts research on drug abuse directly, through the NIMH center in Bethesda, Maryland, and through the Addiction Research Center at Lexington, Kentucky. Extramural research is done by universities, hospitals, nonprofit institutions and agencies of state and local governments financed by NIMH, either by grant or contract.

In pharmacology and biochemistry, much useful research is now being carried on by the National Research Council of the National Academy of Sciences through its Committee on Drug Addiction and Narcotics. Some excellent pharmacological research is being done by the University of Michigan, Department of Pharmacology. NIMH occasionally collaborates with these organizations in special studies and projects and also provides states with professional and technical assistance for the development of community projects.

The NIMH National Clearinghouse for Mental Health Information disseminates basic material on drug abuse to researchers through the distribution of reports, reviews, critiques, and papers summarizing the latest research findings. It also prepares special reports upon request.

The research conducted and financed by NIMH is both basic and applied, and extends from laboratory and clinical studies to field trials and demonstration projects. Some relate directly to drug abuse. Some deal with broader problems, but yield results of immediate benefit. In the five-year period ending June 30, 1963, NIMH spent approximately $6,000,000 (more than half of it in the last two years of the period) for both governmental and extramural research directly related to drug abuse. It is estimated that in fiscal year 1964 NIMH will spend approximately $2,300,000.

In awarding grants for private research, NIMH acts through review panels of scientists who are outside the federal government. Several such groups, each dealing with a different aspect of mental health, pass upon all applications for grants within their respective areas. Before an award may be made, all applications approved must in turn receive the approval of an advisory group composed of persons outside the federal government, called the National Advisory Mental Health Council. The Council meets only three times a year and must pass upon hundreds of grant applications. Under current procedure it operates primarily as a judicial awarding body rather than as an initiating and stimulating one.

According to every informed account given the Commission, NIMH does not lack funds for research. Congress has been appropriating sufficient amounts for mental health research to permit approval of applications for any worthwhile studies of drug abuse. But NIMH does not program its annual budget for private research for specific needs and problems, and there is no earmarking of funds specifically for drug abuse, although NIMH may estimate the amount to be spent in this area each year.

As a result, there is no clear delineation of priorities among the various areas of the mental health problem. The screening of grant applications by the review committees and their approval by the National Advisory Mental Health Council do not provide a satisfactory substitute for direct programming. Each review committee deals with a specific aspect of mental health and does not screen applications with the total problem in mind. The Council meets too infrequently to make a sustained and continuing review of drug abuse. A review of this nature can only be made by NIMH.

The Commission has recommended that NIMH review and earmark for drug abuse a specific amount from its extramural research budget for each fiscal year. This would establish the priority of drug abuse research on the scale of mental health research and would ensure

adequate and continuing funds for non-federal research on drug abuse. The Special Assistant should participate in any review and allocation of funds to be integrated with the Comprehensive Plan of Research.

Stimulating Research

While federal funds are available to finance worthwhile research projects, there does not appear to be sufficient researchers or research organizations willing and able to carry them out. There are several reasons for this.

1. While drug abuse is a serious social problem in the United States, it is not relatively widespread nor is it a problem of uniform national concern.

2. The drug abuser deters many researchers, particularly those who are experimenting with treatment. He is frequently uncooperative, his personality disturbance is profound, and work with him yields limited gains. Beyond this, the omnipresent "dope fiend" image chills the sympathy and interest of potential researchers.

3. There is some fear of prosecution under the federal narcotic laws among medical researchers. The fear grows out of past disagreements between physicians and those charged with enforcement of the federal narcotic laws over the legitimate extent to which a physician may dispense or prescribe narcotic drugs in the treatment of addiction. This fear, though unjustified, nonetheless deters researchers.

The best research follows the inspiration of the individual scientist. But the drug abuse problem has reached a point where a new course of procedure seems advisable. In most instances, those administering federal research funds wait for a researcher or research organization to initiate a project proposal. This process should be reversed. NIMH should be more active in encouraging and assisting researchers and research organizations to undertake desired projects. It may also be valuable to encourage and assist in the enlargement of existing, and the establishment of new, research centers dealing with drug abuse at universities and hospitals.

In addition, there should be increased provision for the training of new researchers. NIMH now conducts and finances some training and education. Fellowships are available to medical undergraduates for summer research, to graduate students, and to postdoctoral candidates. NIMH provides training and instruction at the Addiction Research Center. It grants funds for training programs at university, hospital, and private research centers. But these present training programs do not even come close to filling the existing need for special training. The Addiction Research Center program is informal and lacks accreditation. NIMH should strengthen the association between the Addiction Research Center and universities so that formal, accredited training in areas related to drug abuse

might be developed. NIMH should also approach research centers outside the federal government to develop and undertake new or expanded training programs, and it should provide assistance in the development of the programs. These programs must include a broad scientific education and provide for special study and training applicable to drug abuse.

All demonstration and research projects should be planned so as to provide for a built-in evaluation to chart the progress and efficacy of the individual component parts as well as the final net impact of the total program. The field research should be carried on at the local level using indigenous research personnel whenever possible. The federal government should encourage and assist community efforts in every way. The long range value of community based demonstration projects lies in their transferability for replication in other communities possessing the similar problem and the same resources to use in meeting it.

Colleges and universities should bear a portion of the responsibility for further development of our knowledge of drug abuse. Their resources encompass all the techniques used in research on drug abuse. The research efforts of the government should be meshed wherever possible with the formal educational program of the nation.

Statistical Reporting

The only federal statistics on drug abuse currently available are those collected by the Federal Bureau of Narcotics and the Federal Bureau of Investigation. The Narcotic Control Act of 1956 expressly authorized the Bureau of Narcotics to maintain records of narcotic addicts and narcotic offenders reported by its own agents, by other federal agencies, and by state and local agencies.

Under this authority the Bureau of Narcotics has been compiling records and statistics on narcotic addicts, including the addict's name, aliases, age, sex, race, place of residence, the drug used, the number of years addicted, the original cause of addiction, the addict's source of supply, and the number of previous "cures." The Bureau also maintains records of marihuana offenders. The majority of this information is received from law enforcement sources. It is now being supplemented by reports from the Department of Defense concerning persons rejected for military service because of narcotic addiction.

The Bureau has also solicited information about narcotic addicts from health and welfare sources. However, physicians, hospitals, and health and welfare agencies in most cases object to disclosing such information to any law enforcement agency. This refusal is based on the traditional confidential relationship between the physician and patient. It also reflects a fear that disclosure will discourage drug addicts from seeking treatment for their addiction, as well as for other ailments, and a fear that disclosure of an addict's identity

to a law enforcement agency will lead to harassment, even though he may be undergoing treatment.

Since the Bureau's primary source of statistics is law enforcement agencies, a statistical trend reported by the Bureau may simply reflect a rise or decline in police activity. Many addicts use several aliases and are reported to the Bureau of Narcotics more than once under different names. Although the Bureau furnishes all state and local law enforcement agencies with a uniform reporting form, it has not promulgated uniform standards to guide those using the form—a lack that makes evaluation of its statistics difficult.

The Federal Bureau of Investigation has been receiving voluntary uniform crime reports from state and local law enforcement agencies for many years. These reports identify offenses but not violators. They simply furnish a count of the number of arrests for offenses under narcotic and drug laws. Beginning in 1964, these reports will indicate the drug used. Even then they will be of limited value because they will deal only with the criminal act, and not with the offender. A new statistical program initiated by the Federal Bureau of Investigation in January, 1963, with the cooperation of the International Chiefs of Police and the Federal Bureau of Narcotics, is a promising advance. It deals with known violators and seeks to analyze their criminal histories. The program is still too new for final appraisal.

As a practical matter, most of the statistical information that is available at the Federal level deals with narcotic and marihuana offenders, and not with abusers of other drugs. Because most states have insufficient laws regarding the sale and distribution of dangerous drugs, the uniform crime reports submitted by state and local law enforcement agencies to the Federal Bureau of Investigation do not reflect accurately the number of dangerous drug offenses in the United States.

Whatever the shortcomings of Federal law enforcement statistics, the reporting systems under which they are compiled should be continued and improved. But there should be no unnecessary duplication. If the responsibility for investigating and prosecuting all cases of the illicit possession, manufacture, sale, or other distribution of narcotics, marihuana, and dangerous drugs is assigned to the Department of Justice, as the Commission will recommend in the next chapter, the present statistical reporting system of the Bureau of Narcotics should be worked into the reporting programs of the Federal Bureau of Investigation.

An additional major step is necessary if meaningful statistics are to be collected from both law enforcement and health and welfare sources. Only a Federal health agency can possibly promote the full cooperation of physicians, hospitals, and state and local health and welfare agencies.

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The Commission recommends that the Secretary of Health, Education, and Welfare establish a national reporting system to collect, collate, and analyze data on all forms of narcotic and drug abuse so as to obtain an accurate assessment of the problem. This should be set up on a cooperative basis with federal, state, municipal and private agencies participating.

Such a system would help to identify the drug abuser, furnish basic social and demographic information, record the nature and cause of drug abuse, and indicate any criminal history. If there is to be full cooperation with the system, it is essential that the identity of the individual be kept confidential.

Required reporting of health hazards under governmental authority is a well-established public health practice, and drug abuse is a health hazard. But unlike the usual hazards, it carries possible criminal implications and runs into constitutional blocks. This complicates the problem of securing statistics.

This Commission believes that the best way to establish and maintain a national central reporting system is through a cooperative arrangement for the furnishing and sharing of information between federal agencies and state, local and private organizations. The role of the federal government should be one of assistance and leadership. The federal government can provide the central office, equipment, staffing and operation. The Commission believes that the attainment and maintenance of accurate records require a centrally directed effort that the federal government is best equipped to assume.

V

CONTROL OF THE DRUG TRAFFIC

Federal Organization

It was suggested to the Commission by eminent authorities that all functions concerning drug abuse be withdrawn from their present federal departments, agencies, bureaus, and divisions and centered in one agency devoted exclusively to this problem. This is an extreme view, and one in which the Commission does not concur. Although some specialization is necessary, it believes that these operations are most effective when carried out in the context of other law enforcement responsibilities and in accordance with basic procedures of the social sciences.

The Secretary of the Treasury is the cabinet officer now charged with the responsibility for investigating offenses arising from the unlawful trafficking and possession of narcotic drugs and marihuana. He also has the responsibility for regulating the legitimate importation, exportation, manufacture, sale, dispensing, and other distribution of these substances. He acts through the Commissioner of Narcotics, the chief officer of the Bureau of Narcotics.

Five statutes vest primary control of narcotic drugs and marihuana in the Secretary of the Treasury:

1. *The Harrison Act*, enacted in 1914, requires that all persons who import, manufacture, sell, deal in, dispense, or otherwise distribute narcotic drugs register with the Secretary and pay an occupational tax. It imposes a commodity tax of one cent per ounce on all narcotic drugs produced in or imported into the United States and sold or removed for consumption or sale. It also requires that any transfer of narcotic drugs be made on a special Treasury order form, with exceptions for physicians who dispense narcotics to patients in the course of professional practice only and for pharmacists who fill lawful written prescriptions.

This method of regulation by taxation, which resulted in the vesting of narcotics control in the Department of the Treasury, can only be understood in its historical setting. When the Harrison Act was drafted, Congress was concerned about its constitutionality. The landmark cases establishing the full sweep of federal regulatory power under the commerce clause of the Constitution were yet to come. Moreover, the federal government had had little experience with direct regulation of the manufacture and transfer of drugs in general.

2. *The Narcotic Drugs Import and Export Act*, first enacted in 1922, authorizes the Secretary to regulate the importation of crude opium and coca leaves for medical or scientific uses. It prohibits the importation of opium for the manufacture of heroin and opium prepared for smoking, and it authorizes the Secretary to regulate the export of narcotic drugs to ensure that they are intended exclusively for medical or scientific needs in the country of destination.

3. *The Marihuana Tax Act*, enacted in 1937, requires that all persons importing, manufacturing, selling, or otherwise distributing marihuana register with the Secretary of the Treasury and pay a graduated occupational tax. All transfers of marihuana are taxed, at $1.00 per ounce if the transferee is registered and has paid an occupational tax under the Act, and $100.00 per ounce if the transferee is not registered. The rate for transfers to persons who are not registered taxpayers is prohibitory. Transfers must generally be made on special Treasury order forms.

4. *The Opium Poppy Control Act*, enacted in 1942, authorizes the Secretary of the Treasury to license the production of opium poppies upon a determination that domestic production is necessary to meet domestic medical or scientific needs. No license has been issued under this Act.

5. *The Narcotics Manufacturing Act of 1960* authorizes the Secretary of the Treasury to establish quotas limiting the manufacture of natural and synthetic narcotics and to license all manufacturers.

The Transfer of Functions within the Executive Branch

The Bureau of Narcotics is an anomaly in the Department of the Treasury. The Bureau estimates that approximately 80 percent of its activities are devoted to the investigation and control of the illicit traffic in narcotic drugs and marihuana—traditionally police work. The remaining 20 percent is devoted to regulating the legitimate manufacture and transfer of narcotics. The Bureau is not a revenue-collecting unit. The amounts collected under the Harrison Act are relatively minor, and the Marihuana Tax Act yields nothing because the tax rate is deliberately prohibitive. Taxation is in fact only a guise for law enforcement and regulation.

> *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.*

The primary functions of the Treasury Department concern fiscal and monetary matters. In these vital affairs, the country looks to the Treasury. To the extent that its top officials must give time and energy to a major criminal problem outside the realm of fiscal affairs,

the attention given the prime responsibilities of the Department must necessarily be diluted. Police work to stem the illicit traffic in drugs is a major criminal problem. And it requires a peculiar training and experience not normally possessed by officials chosen for expertise in the complexities of governmental finance, however earnest and dedicated they may be.

However, there is in the federal government a top line of command professionally chosen and trained for law enforcement. It is in the Department of Justice, whose principal concern is the investigation and prosecution of criminal violations of federal law. The Federal Bureau of Investigation, the United States Attorneys, the Board of Parole, the Pardon Attorney, the Bureau of Prisons, and the United States Marshals are all located in the Department of Justice.

The investigation and prosecution of the illicit traffic in narcotics and marihuana is no minor task. This illicit traffic is one of the major areas of concern at all levels of law enforcement in this country, and it is one of the principal activities and primary sources of income of organized crime. Yet the Department of Justice lacks direct command over the agency primarily responsible for investigating this illicit traffic. Only informal interdepartmental cooperation links the two. Transfer of this investigative responsibility from the Department of the Treasury to the Department of Justice would remedy this. The Hoover Commission pointed out in 1949 that the police work of the Bureau of Narcotics involves much the same set of relationships with state and local law enforcement agencies as that maintained by the Department of Justice. In that Commission's view, transfer of this work to the latter Department would facilitate narcotic crime detection in the United States. That Commission recommended the transfer but thought that the two functions of regulation and law enforcement ought not be split. There was no Department of Health, Education, and Welfare at that time.

This Commission cannot find any present international treaty obligations that require the investigative and regulatory functions of the Bureau of Narcotics be vested in a single agency. In an historical and technical study of the 1931 Convention made in 1937, the Opium Traffic Section of the Secretariat of the League of Nations stated that the provision in Article 15 of that Convention for the creation of a special administration "does not necessarily mean a single authority." We are advised that Canada has this work in two authorities, each a "special administration". The Commission can find no provisions in the statutes to indicate that the Bureau of Narcotics has special powers relating to search warrants which would be lost if the Bureau ceased to be constituted as it now is.*

*United States Code, Title 18, Section 1405. The section makes special search authority available for certain federal narcotics offenses, but without limitation to officers of the Bureau of Narcotics.

It was urged upon this Commission that the same considerations which indicate the transfer of the Bureau's investigative functions in narcotics cases to the Department of Justice would logically require the transfer to that Department of some 25 other investigative units scattered throughout the federal establishment. This position is untenable because most of the other investigative units are engaged in investigative work which relates directly to the overall operation to which they are attached. For example, the special intelligence unit of the Internal Revenue Service investigates violations of the tax laws. Enforcing the tax laws is the business of that Service, and the intelligence unit is logically an integral part of it. But the investigation of the illicit traffic in narcotics is almost wholly foreign to the duties of the Department of the Treasury. It is, however, directly related to the primary mission of the Department of Justice.

This recommendation is not to be viewed as in any way a reflection upon the Bureau of Narcotics which has made substantial contributions to the fight against the illicit traffic in narcotic drugs and marihuana. Administrative logic, principles of effective government, and plain common sense dictate that the functions of the Bureau relating to the investigation of the illicit traffic in narcotic drugs and marihuana be transferred from the Department of the Treasury to the Department of Justice. Whether the Bureau should remain constituted as a separate unit within the Department of Justice should be decided by the Attorney General.

Many advantages would accrue from the creation of special teams of narcotics agents and lawyers within the Department of Justice to deal with cases of large-scale trafficking. Cases involving large-scale, well-financed traffickers require long periods of preparation. Investigating such offenses and bringing the offenders to justice involves not only difficult problems of fact, but many complex and delicate questions of law. They involve the obtaining of evidence, the snares of entrapment, the essentials of search warrants, the service of search and arrest warrants, the permissible circumstances for arrests without warrants, the rights of an arrested person, and the elements of the offense which has been committed. These big cases are not concluded when arrests are made or indictments handed down. They are only concluded when a judge or jury has declared the accused guilty or not guilty, and frequently only after the case has undergone review by appellate courts. Any case presented by the government must stand up in court, factually and legally.

The proposed team would be made up of as many investigators and lawyers as needed, who would be assigned to a case at the outset and work on it until final disposition, with the assistance of the appropriate United States Attorney, agents of the Federal Bureau of Investigation, customs officers, and other federal resources. The lawyer on such a team could remain all the way with the case.

In contrast to the extensive statutory provisions for federal control of the manufacture, sale, and other distribution of narcotic drugs and marihuana, there is limited federal authority over dangerous drugs. The Federal Food, Drug, and Cosmetic Act now requires only that these drugs meet certain standards of safety and efficacy, be labeled as habit-forming, be dispensed by prescription, and that the manufacturers of dangerous drugs register with the Department of Health, Education, and Welfare. The Secretary of that Department administers the regulatory powers of the Federal Food, Drug, and Cosmetic Act. He acts through the Commissioner of Food and Drugs, who is the chief officer of the Food and Drug Administration.

There are special penalties for the unlawful importation of narcotic drugs or marihuana (in the Narcotic Drugs Import and Export Act), but none for the unlawful importation of dangerous drugs. The smuggling of dangerous drugs is covered only by the general smuggling law, set forth in the United States Code, Title 18, Section 545. The Bureau of Customs receives assistance from the Bureau of Narcotics and the Food and Drug Administration in the prevention and detection of the smuggling of dangerous drugs.

The apparent increase in the abuse of dangerous drugs is a most recent and alarming development. There are huge illicit sales of these drugs. They contribute to criminal behavior, particularly among juveniles and young adults. The record of the Food and Drug Administration in stopping illicit sales of dangerous drugs is unsatisfactory, partly due to the limited statutory power of the federal government. The Federal Food, Drug, and Cosmetic Act does not now permit detailed regulatory control. The record of enforcement by the Food and Drug Administration in this area also reflects a lack of sufficiently trained inspectors with the traditional authority of law enforcement officers to carry weapons, to search and seize, and to make arrests. In considerable part, it reflects a lack of knowledge in police techniques, understandable in an agency primarily devoted to ensuring the safety of food, drugs, and cosmetics.

The Commission recommends that the responsibility for the investigation of the illicit traffic in dangerous drugs be transferred from the Department of Health, Education, and Welfare to the Department of Justice.

The transfer of the responsibility for dealing with the illicit traffic in dangerous drugs to the Department of Justice would bring the investigatory skill and law enforcement experience of the Department to bear with full force on the problem.

The Commission recommends that the functions of the Bureau of Narcotics relating to the regulation of the legitimate importation, exportation, manufacture, sale, and other transfer of

narcotic drugs and marihuana be transferred from the Department of the Treasury to the Department of Health, Education, and Welfare. Narcotic drugs would be regulated under the power to regulate interstate and foreign commerce, not under the tax power; and the importation, production, sale, or other transfer of marihuana would be prohibited except where expressly licensed for legitimate scientific purposes or for the emergency production of hemp.

There is no reason why the legitimate manufacture, sale, dispensing, and other distribution of narcotic drugs should be controlled as an incident of the collection of excise revenue. Since 1914 the federal government has acquired extensive experience with direct regulation of harmful substances of all kinds. There is no longer constitutional doubt that the federal government may control the domestic manufacture and transfer of narcotic drugs under its power to regulate interstate commerce. Under these circumstances administrative logic should be a controlling consideration, and the Secretary of Health, Education, and Welfare should be charged with the duty of regulating the legitimate manufacture and transfer of narcotic drugs and marihuana in addition to his duties in respect to other dangerous drugs under the Federal Food, Drug, and Cosmetic Act.

This transfer of responsibilities from the Secretary of the Treasury to the Secretary of Health, Education, and Welfare would require the enactment of new regulatory authority to replace the Harrison Act. The transfer of responsibilities would also require the transfer to the Secretary of Health, Education, and Welfare of the authority now vested in the Secretary of the Treasury to regulate the legal importation of crude opium and coca leaves and the exportation of narcotic drugs under the Narcotic Drugs Import and Export Act, and to establish quotas for and to license the manufacture of natural and synthetic narcotics under the Narcotics Manufacturing Act of 1960.

New statutory authority should also be substituted for the Marihuana Tax Act. The practical purpose of that Act is to limit the acquisition of marihuana by imposing a prohibitory tax on all transfers of marihuana. According to the Commission on Narcotic Drugs of the United Nations Economic and Social Council, "cannabis [marihuana] appears to have no beneficial effects in modern medicine."* Thus there is no need to perpetuate the myth of its availability subject to payment of a transfer tax. The new statute would prohibit the importation of marihuana, the domestic production of marihuana, and all sale or other transfer of marihuana within the United States, except where importation, production, or transfer is expressly licensed by the Secretary of Health, Education, and Welfare.

* Report of the Eighteenth Session, April 29–May 17, 1963, par. 203.

The exception would permit marihuana to be obtained when needed for legitimate scientific purposes. It would also permit cannabis to be grown for the manufacture of hemp when an emergency limits the availability of other forms of hemp as happened during World War II.

The Commission recommends that a unit be established within the Department of Health, Education, and Welfare to determine the safety and efficacy of and to regulate all narcotic and dangerous drugs capable of producing severe psychotoxic effects which can lead to criminal or lawless behavior when abused. This unit would also regulate the legitimate importation, exportation, manufacture, sale and other transfer of narcotic and dangerous drugs.

The new unit should control the legitimate importation, exportation, manufacture and transfer of narcotic drugs; it should license the importation, production, and transfer of marihuana in those rare instances in which a license may be justified; and it should regulate the legitimate manufacture and distribution of dangerous drugs. A special unit could concentrate attention on these drugs. It would also permit those charged with the daily task of regulation to build up a degree of special knowledge that is presently impossible to acquire in the Food and Drug Administration, that is primarily responsible for testing and evaluating countless other foods, drugs, and cosmetics.

The statutes setting forth these regulatory powers should vest them in the Secretary of Health, Education, and Welfare. The Secretary should be empowered to determine by regulation, under proper rule-making procedures, the specific psychotoxic drugs—now existing and yet to be developed—which fall within the jurisdiction of the proposed unit.

The Need for Additional Enforcement Personnel

Almost all the narcotic drugs in illicit traffic in the United States are smuggled into the country. The principal smuggled drug is heroin, only a small fraction of which is intercepted each year by the Bureau of Customs. The Department of the Treasury estimates that at present approximately 1½ tons of heroin are illegally brought into the United States annually. By contrast, in fiscal year 1962, the Bureau of Customs intercepted approximately 5 pounds of heroin; and in fiscal year 1963, approximately 35 pounds. In addition, other dangerous drugs are smuggled from Mexico; their presence in California, as well as in other border states, constitutes a grave problem.

The Commission recognizes the difficulty of intercepting the smuggling of narcotic and dangerous drugs. Over 160 million persons enter the United States annually at its ports of entry. The Mexican and Canadian borders are long and cannot be entirely policed. The

investigative force of the Bureau of Customs is woefully undermanned, and no group concedes this more readily than the Bureau itself. The present budget of the Bureau of Customs provides for 484 Customs Port Investigators and 245 Criminal Investigators (the latter are the higher-echelon investigators within the Bureau). With this force the Bureau must cover all seaports, all international airports, and the two borders, not only to intercept narcotic and dangerous drugs, but for all other customs investigations.

Effective customs enforcement in narcotics is virtually impossible with a force of this size. The Bureau informed this Commission that its force of Customs Port Investigators should be double, at the least, and its force of Criminal Investigators increased by 50 persons. The Commission agrees. Additional investigative personnel, properly trained and properly equipped, would permit more frequent and more thorough searches. Tighter controls would result in more interceptions of narcotics and dangerous drugs and in greater quantities. While the smuggling of drugs can probably never be wholly eradicated, tighter controls would be a substantial deterrent to smuggling. Drug smuggling is a federal crime which only the federal government can control.

At present, the regular strength of the Bureau of Narcotics is 435 positions. Of these, 297 are enforcement agent positions. Fourteen narcotics agents are assigned to service in eight foreign countries—Italy, France, Turkey, Lebanon, Thailand, Malaysia, Hong Kong, and Mexico. They cooperate with and assist foreign governments in controlling the illicit international traffic in narcotic drugs. The remaining 283 authorized agents are assigned within the United States, which is subdivided for administrative purposes into 13 districts. In addition to the district headquarters offices in 13 cities, the Bureau maintains branch offices in 28 additional American cities.

The size of the agent force of the Bureau of Narcotics in foreign nations appears inadequate to aid the host country and assist in detecting and preventing illicit shipments to the United States. The Bureau has only one agent programmed for cities like Beirut, Paris, Istanbul, Singapore, and Hong Kong, and these agents are there to render assistance throughout the entire host country. In the Commission's opinion, more agents should be assisting foreign law enforcement authorities. This may require new agreements with the host countries, but such agreements appear feasible. The illicit traffic in narcotic drugs within the United States begins overseas, and much of it can be controlled by assisting foreign law enforcement officers within their own countries.

It is difficult to see how the Bureau of Narcotics can adequately staff its offices in 41 American cities with only 283 agents. These agents must enforce the Harrison Act, the Marihuana Tax Act, and the trafficking provisions of the Narcotic Drugs Import and Export

Act. They must assist state and local law enforcement officers in narcotics control. They must assist the Bureau of Customs in the detection of narcotics smuggling. Narcotic abuse is centered in a few large urban areas and more than half the Bureau's agent force is concentrated in the cities of highest incidence. But even where there is concentration, the Bureau has an insufficient number of agents to cope with the task.

In New York City, the busiest port of entry in the United States, with an addict population estimated to range anywhere from 22,000 to 50,000, the Bureau maintains a force of only 85 agents. In Chicago, the second largest city in estimated addict population, through which much of the interstate shipment of illicit narcotics passes, the Bureau maintains a force of only 40 agents. In Los Angeles, the third largest city in estimated addict population, the Bureau maintains a force of from 25 to 30 agents.

The Bureau of Narcotics contends that its present small force of mobile and highly trained narcotic agents is sufficient because these agents are supplemented in our cities of highest incidence by trained state and local narcotic officers. But the fact remains that the estimated American addict population numbers tens of thousands and the annual illicit traffic in narcotic drugs is estimated in the hundreds of millions of dollars.

The Commission has commented on the inability of the Food and Drug Administration to halt the ever-mounting volume of illicit sales in dangerous drugs. This is partially due to a grossly inadequate staff of properly trained and equipped enforcement agents. During fiscal year 1963, the Food and Drug Administration had a staff of 120 devoted to the regulation of dangerous drugs. Only 40 of them were inspectors investigating illicit sales of dangerous drugs. In fiscal year 1964, the Food and Drug Administration will increase this staff by 20, of whom 14 will be inspectors.

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

All three investigative agencies now concerned with narcotics and dangerous drugs are undermanned. If the reorganization recommended in this report is to be put into effect, adequate personnel must be provided.

Statutory Penalties

Present federal narcotics and marihuana laws set forth a complex pattern of offenses. For the present bewildering variety of offenses the present federal narcotics and marihuana laws prescribe a range of mandatory minimum sentences: They impose a minimum sentence of

two years for a first offense of possession of narcotics or marihuana, and a minimum of five years for a second offense, and a minimum of ten years for any subsequent offense. They impose a minimum sentence of five years for a first offense of smuggling, selling, or otherwise transferring narcotics or marihuana, and a minimum of ten years for a second or subsequent offense. These laws forbid the probation or parole of any offender except a first offender whose crime is the possession of narcotic drugs or marihuana.

These sentencing provisions have deprived the federal courts of almost all discretion in sentencing and have had discernible adverse effects. They have made rehabilitation of the convicted narcotics offender virtually impossible. Those who have dealt with narcotic offenders in the federal prisons agree that there is little incentive for rehabilitation where there is no hope of parole. Moreover, parole would provide for extensive supervision of the narcotic abuser following his release from prison.

The Bureau of Narcotics maintains that the present severe penalties act as a powerful deterrent. The Commission does not agree. As the Commission pointed out in its introduction, it is difficult to believe that a narcotic addict who is physically and psychologically dependent on a drug will forego satisfaction of this craving for fear of a long prison sentence, or that a marihuana user obsessed by the "high" sensation of marihuana will think of the penalty that awaits him if he is caught possessing it. The weakness of the deterrence position is proved every day by the fact that the illicit traffic in narcotics and marihuana continues.

The basic theory of the present penal provisions is that offenses under the narcotics and marihuana laws are, regarded collectively, offenses of equal gravity. This should not be so. While there is some overlap among all these offenses, important differences in their underlying criminal content do exist.

In terms of gravity, narcotics offenses fall into three categories:

1. The smuggling of or trafficking in narcotics in large quantities and the possession of narcotics in large quantities for sale. In the Commission's view, and in the view of every informed observer, these are heinous crimes. They are committed primarily by hardened criminals, whose sole interest lies in reaping huge profits and who profit from the weakness and misery of the narcotic abuser. The traffickers are seldom addicts themselves.

2. The smuggling, selling and giving away of narcotics in small quantities and the possession of narcotics in small quantities for sale. This offender is most often a narcotic addict himself. He may be trying to finance his habit or to create a drug companion or to accommodate a fellow addict who will in turn reciprocate on occasion. This crime is likewise a serious one. The person who sells or gives away

small quantities is contributing to the narcotic habit of another, and the same may well be true of the small-scale smuggler.

3. The possession of narcotic drugs without intent to sell. One cannot quarrel with the view that narcotic drugs can be extremely harmful to the individual and to society. The abuse of the opiates can lead to a lifetime of physical dependence, and the abuse of cocaine can lead to aggressive forms of illegal behavior. Thus the possession of narcotics (other than by doctors, researchers, and others similarly engaged) is and should continue to be forbidden by law. Possession without intent to sell, however, should not be equated with selling or smuggling.

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.

These amendments should provide:

1. That mandatory minimum sentences and a prohibition of both probation and parole be retained for offenders smuggling or selling in large quantities or possessing large quantities for sale.

2. That the offender who smuggles, sells or gives away small quantities or possesses small quantities for sale should receive some measure of imprisonment. The Commission believes that he should be subject to a fixed maximum sentence and be denied any suspension of sentence, but that he should not be subject to a mandatory minimum sentence and not be denied the hope of parole.

3. That the federal courts be given complete discretion in the sentencing of those whose offense is possession without intent to sell. There should be no mandatory minimum sentences for these offenders and no prohibition of probation and parole. The court would, as appropriate, impose a fixed maximum sentence (with eligibility for parole), suspend sentence, or impose an indeterminate sentence under the Federal Youth Corrections Act or the Act of August 25, 1958.* The person who buys narcotics for his own use is similar to the person whose offense is possession without intent to sell, and he should be treated likewise in any amended revision of narcotics penalties.

In recommending that the offender smuggling or selling large quantities and the offender smuggling or selling small quantities be subject to different sentencing, the Commission is not setting up a novel

*United States Code, Title 18, Sections 4208–4209. The act authorizes indeterminate sentences for adult offenders (over the age of 25) and makes the sentencing provisions of the Federal Youth Corrections Act available to offenders between the ages of 22 and 25 inclusive.

distinction. The recommendation will require that a line be drawn between a small quantity and a large one, but such lines are frequently drawn in law. For example, the Seventh Amendment preserves the right to trial by jury in common law suits in controversies exceeding $20. Almost all criminal codes differentiate between grand larceny and petty larceny. A factor in a legal vote or a legal contract is an arbitrary line based on age.

The present federal narcotics and marihuana laws equate the two drugs. An offender whose crime is sale of a marihuana reefer is subject to the same term of imprisonment as the peddler selling heroin. In most cases the marihuana reefer is less harmful than any opiate. For one thing, while marihuana may provoke lawless behavior, it does not create physical dependence. This Commission makes a flat distinction between the two drugs and believes that the unlawful sale or possession of marihuana is a less serious offense than the unlawful sale or possession of an opiate.

The Commission believes that the sentencing of the petty marihuana offender should be left entirely to the discretion of the federal courts. There should be no mandatory minimum sentences for marihuana offenders and no prohibition of probation and parole. The courts should have the discretion to impose a fixed maximum sentence (with eligibility for parole), to suspend sentence, or to impose an indeterminate sentence. The Commission is opposed to mandatory minimum sentences, even in the case of multiple offenders.

The Commission feels that any legislation amending the penalty provisions of the federal narcotics and marihuana laws should authorize a review of the sentences of the offenders presently serving mandatory minimum sentences and should permit parole to be granted where justified.

While the Commission's recommendations on statutory penalties relate only to the federal narcotics and marihuana laws, it is the hope of the Commission that its recommendations will serve as a guide for the states in the amendment of existing state laws to conform more closely to the federal revisions recommended.

The complex pattern of offenses under the federal narcotics and marihuana laws has created a special sentencing problem. Under these laws a single sale of narcotic drugs may violate several statutory provisions. It may constitute at one and the same time a violation of the prohibition of the Narcotic Drugs Import and Export Act against trafficking in illegally imported narcotics, a failure to comply with the requirement of the Harrison Act that a transfer of narcotic drugs be made pursuant to a written order on the prescribed Treasury form, and a failure to comply with the requirement of the Harrison Act that narcotic drugs shall be sold in or from the original package containing the requisite tax stamps. If there is a verdict of guilt

on several counts, separate sentences may be imposed upon each, the result being a cumulative sentence considerably more severe than the total narcotics transaction warrants.

At the meeting of the Judicial Conference of the United States on March 11–12, 1963, the Chairman of the Committee on the Administration of the Criminal Law informed the Conference of the mandate given this Commission by President Kennedy. The Conference authorized the Committee to cooperate with the Commission and to report on the Commission's proposals. The Commission suggests that the Attorney General utilize this proffered channel of communication to invite to the attention of the Judiciary the problem of the cumulative sentence in narcotics cases.

Dangerous Drugs

The Federal Food, Drug, and Cosmetic Act requires that dangerous drugs be dispensed by prescription only, but it does not authorize any further control of their dispensing. As a result, there are extensive illicit sales of these drugs.

On January 28, 1963, Senator Thomas J. Dodd submitted to the Senate a bill (S. 553) to provide close federal regulation of the manufacture, sale, and distribution of certain dangerous drugs, notably the barbiturates and amphetamines. Under the proposed legislation only manufacturers of pharmaceutical drugs who have registered with the Secretary of Health, Education, and Welfare would be authorized to produce the drugs covered by the particular bill. The cycle of distribution from manufacturer to patient would be regulated by requiring all manufacturers, all wholesale and retail pharmacies, and all clinics and laboratories to be accountable for all such drugs manufactured, shipped, received, sold, dispensed, or distributed. They would be required to keep inventory records, which would be available for inspection by federal officers. A similar bill (H.R. 6846) was submitted to the House of Representatives by Congressman James J. Delaney.

The Commission recommends that all non-narcotic drugs capable of producing serious psychotoxic effects when abused be brought under strict control by federal statute.

The manufacture, sale, and distribution of dangerous drugs is a national business, conducted across state lines, and the interstate character of the traffic, both licit and illicit, limits the ability of any single state to cope with its individual problem. Only the federal government can provide uniform minimum standards of regulation. Reliance on state laws for complete record keeping would prove chaotic. The Commission favors the plan of regulation proposed by the Dodd-Delaney bill.

The Commission makes several specific observations concerning any new legislation providing for federal regulation of the manufacture, sale, and distribution of dangerous drugs:

1. Legislation should not be limited to the barbiturates and amphetamines, but should extend to all non-narcotic drugs capable of producing serious psychotoxic and antisocial effects when abused. Experience has proved that the drug abuser often turns to other drugs having similar effects when barbiturates or amphetamines become difficult to obtain. Any new legislation should be broad enough to include all hypnotic, stimulant, and depressant drugs affecting the central nervous system in such a way as to be classified as psychotoxic. The bill's definition of its coverage should not, however, interfere with legitimate medical usage. The bill should exempt any drug within this definition that combines a small amount with other substances where the resultant drug is not itself liable to abuse.

2. In determining the specific drugs which fall within the scope of his regulatory power over dangerous drugs, the Secretary of Health, Education, and Welfare should be advised by a standing committee composed of experts from both within and without the federal government and should act in accordance with fair rule-making procedures.

3. It should always be recognized that such dangerous drugs are medically valuable. They are prescribed or dispensed by physicians in millions of cases each year. The Commission believes that any new regulation covering their manufacture, sale, and distribution should not parallel the form of regulation under existing Federal narcotics laws which require all narcotic drug transfers to be registered with the Federal Government on Treasury forms. The stringent controls of the narcotics laws might seriously hamper the legitimate medical use of these other drugs. The use of special registration forms for dangerous drug transfers may eventually prove to be a necessity to achieve adequate control over the distribution of these drugs. However, experience with regulation based on the keeping of inventory records should be developed first.

The Dodd-Delaney bill would exempt physicians from such record-keeping. Physicians personally dispense comparatively small quantities of these drugs, in countless cases ranging from minor surgery to sleepless anxiety. The dispensing of dangerous drugs by a pharmacist, on the other hand, should always be made pursuant to a written prescription. In the case of the pharmacist there is no analogue to the physician's practice of dispensing, for example, a few barbiturate pills. On the basis of current study, retail pharmacies and pharmacists appear to be a major source for the diversion of dangerous drugs to illicit channels in the United States. In the ten-year period ending December 31, 1962, there were 1,658 firms and individuals convicted under the Federal Food, Drug, and Cosmetic Act for the illegal sale

of amphetamines and/or barbiturates. Of these convictions, 1,298, or 78 percent of the total, involved retail drug firms, pharmacists, or their employees. This figure is unfortunate, for these offending pharmacies and pharmacists represent only a small fraction of the nation's total and indict the rest of the profession by these acts.

Assistance to State and Local Law Enforcement Agencies

The illicit domestic traffic in narcotic drugs and marihuana is not only a federal matter; it is equally a violation of state law, and state and local law enforcement agencies assume considerable responsibility for controlling this traffic. The federal government can assist these agencies by making available the experience and expertise of its narcotic enforcement personnel.

This is now being done to some extent. The Narcotic Control Act of 1956 authorized the Secretary of the Treasury to conduct narcotics training programs for state and local law enforcement officers, and in October, 1956, the Bureau established a formal training school in Washington, D.C. The school provides an intensive two-week course on the latest law enforcement techniques in the field of narcotics control. Between the school's inception and the end of fiscal year 1963, the school provided training to 1,152 persons, mostly state and local law enforcement officers. In fiscal year 1964, the school will hold eight two-week sessions and expects to train an additional 200–250 persons. Despite this good work, the Bureau can and should reach more state and local officers.

The Commission recommends that the training school now conducted by the Bureau of Narcotics be more fully publicized among state and local law enforcement agencies, that in-service training sessions, workshops and seminars be conducted in the areas where drug abuse is most prevalent, and that the federal government provide field training courses for the dissemination of current federal information on narcotics control to state and local law enforcement officers.

The existence and availability of the school should be better known in law enforcement circles. Training teams should be sent into the field to conduct in-service sessions of the school in localities where narcotic abuse and the illicit traffic are most prevalent. Most local police departments lack sufficient funds to send the desired number of officers to a federal narcotic training school. This is particularly true of California law enforcement agencies because of high travel costs. By bringing the training school to the locality, technical training could be provided to a substantially larger number of state and local law enforcement officers. Even where the local police department provides its own narcotics training to its officers, as in New York City and Los Angeles, the federal government can

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still play a valuable role. Its knowledge of narcotics control techniques and problems is much more extensive than that of any state or local law enforcement agency, and it can provide supplemental training.

The need for continuing training to keep state and local law enforcement officers abreast of the latest technical information on the illicit narcotics traffic and on law enforcement is equally important. The federal government should establish a center to collect, prepare, and disseminate the materials necessary to keep state and local law enforcement officers informed. Field training teams would prove invaluable in providing refresher courses to state and local officers.

International Aspects

Wiretapping

The importation of heroin into the United States and its manufacture here are prohibited: thus all heroin in the United States is smuggled. Even with a larger force of agents the detection of heroin in the course of smuggling is immensely difficult; and for purposes of interception, law enforcement must have advance information of plans to smuggle heroin into the United States.

In some instances this information is obtained by the infiltration of federal agents into groups engaged in the smuggling of narcotics or by the use of paid informers. But the smuggling of narcotics is primarily in the hands of highly-organized criminals, who are skillful and ruthless in shielding their activities. Information about the smuggling of heroin can in most instances only be obtained by intercepting the telephone communications of those so engaged.

The right of privacy of the individual is a sacred right in America. While wiretapping is not unconstitutional,* it is an invasion of privacy and in good conscience its use can only be permitted to meet the most serious threats to society—and then only where there are no other means readily available to meet the particular threat. The Commission believes that the illegal importation of narcotics into the United States is a threat of this magnitude.

> *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.*

Wiretapping would be strictly confined to the international smuggling of narcotics and hence would be used only in limited circumstances.

The authority to intercept telephone communications involving the illegal importation of narcotics should be strictly controlled to avoid

*The United States Supreme Court upheld the constitutionality of wiretapping in 1928. *Olmstead* v. *United States*, 277 U.S. 438.

abuse. Wiretapping should be permitted only under an order issued by a judge of the United States District Court. Only the Attorney General, or the Deputy Attorney General or an Assistant Attorney General if expressly authorized by him, should be empowered to authorize formal application for a court wiretapping order.

The application should set forth a full and complete statement of the facts, the nature and location of the telephone facilities involved, and all previous applications involving the same facilities or the same person named in the application. The court should issue an authorizing order only where the judge determines that probable cause exists for belief that an offense involving the illegal importation of narcotic drugs is being or is about to be committed; that facts concerning the offense may be obtained by wiretapping; that no other means are readily available for obtaining that information; and that the telephone to be tapped may be involved in the offense.

The order itself should specify the nature and location of the telephone facilities to be tapped, the offense for which information is sought, and the identity of the federal agency authorized to tap. The order should be limited in time and clearly state its duration. Any extension of the order should require a fresh application to the court and a fresh determination by the judge as to the findings on which the order is based. Any such legislation authorizing the use of wiretapping in cases involving the illegal importation of narcotic drugs 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. The legislation should further require that the extent of wiretapping in cases involving the illegal importation of narcotic drugs be reported periodically for review of the operation of the statute.

The Smuggling of Dangerous Drugs

The smuggling of dangerous drugs between Mexico and the United States has prompted some observers to propose that Congress authorize the imposition of controls over the exportation of dangerous drugs. A significant portion of the dangerous drugs smuggled in from Mexico is manufactured in the United States and then legally exported to outlets in Mexican border towns. Here the drugs are purchased and illegally brought back into the United States. The desired effect of export controls would be to limit the amount of dangerous drugs that could be exported to Mexican outlets by American firms and thereby to dry up these outlets as purchase sources for smugglers. If the American firms were the sole source of potential supply for the Mexican outlets, the Commission would have no hesitancy in recommending legislation that would impose such controls on the exportation of dangerous drugs. But dangerous drugs are also available from drug manufacturers in other countries, and Mexican pharmaceutical

firms are equally capable of producing them. This situation can best be met by international controls.

The Commission recommends that the United States request the United Nations to establish a system of international control of the distribution of dangerous drugs. The Commission does not see the necessity of new federal legislation to supplement the general smuggling law by expressly prohibiting the illegal importation of dangerous drugs into the United States.

Some observers have recommended that Congress enact a statute prohibiting the illegal importation of dangerous drugs to supplement the general smuggling law (United States Code, Title 18, Section 545). The Commission views additional legislation as being of relatively little value, since the general smuggling law already provides for a maximum prison term of five years. The answer is not to enact stronger laws, but to strengthen enforcement of the existing laws. If the Bureau of Customs can institute more frequent and more thorough searches at the points of entry along our borders, as the Commission has suggested, drug smuggling should decline markedly.

Joint United States-Mexico Commission

The Commission has heard authoritative descriptions of extensive smuggling of narcotic drugs, marihuana, and dangerous drugs between Mexico and the United States. In some Mexican districts opium poppies are grown clandestinely and converted to heroin. Some of the narcotic drugs originate outside Mexico and are smuggled into the United States through Mexico because of our difficulty in policing the 2,000-mile-long Mexican border. Marihuana smuggled into the United States originates almost entirely in Mexico. Most of the dangerous drugs smuggled into this country are manufactured here and then exported legally to Mexico—whence they are smuggled back into the United States.

In recent years, both the United States and Mexico have intensified their efforts to halt the illicit flow. The Bureau of Customs has assigned more investigators and agents to the Mexican border to tighten border control. The Bureau of Narcotics has now programmed three agents to assist Mexican law enforcement officers. The Mexican authorities, using light planes, helicopters, and flame throwers provided by the United States through its Agency for International Development (AID), have located and destroyed some of the clandestine poppy fields.

Although these are steps in the right direction, they are still insufficient. This Commission has indicated the need for a drastic increase in the total investigative force of the Bureau of Customs,

which would permit the Bureau to tighten its control along the Mexican border.

The Commission recommends that the United States invite the Mexican government to assist in the establishment of a Joint United States-Mexico Commission for consultation on the development of better methods to curb the illegal flow of narcotics, marihuana, and dangerous drugs between Mexico and the United States.

United States cooperation with and assistance to the Mexican authorities on a day-to-day basis cannot be achieved simply by assigning three agents to Mexico. Unilateral action and liaison at the working agent level is not enough. There should also be continuing and complete consultation between the two governments at a high level. Halting the flow of narcotics, marihuana, and dangerous drugs between Mexico and the United States is of mutual concern to both governments, as President Mateos and President Kennedy acknowledged when they met in Mexico City in June 1962. But the problems of enforcement differ on each side of the border, and without full consultation neither government can fully comprehend the exact nature of the problems faced by the other. For this reason the Commission feels strongly that a Joint United States-Mexico Commission should be established to provide a ready forum for consultation. The Joint Commission should be charged with making recommendations for specific action by the member governments, either separately or jointly.

Treaties on Opium Production

The established policy of the United States has long been to enter into multilateral treaties that would limit the cultivation of the opium poppy and the production of opium so that less opium would be available to the illicit international traffic. The latest opium production treaty ratified by the United States is the Protocol of 1953, a United Nations instrument which came into force on March 8, 1963. Now pending for ratification of member nations is the Single Convention on Narcotic Drugs, 1961, a United Nations instrument designed to codify and eventually to supersede eight existing multilateral treaties relating to narcotic drugs, including the Protocol of 1953, and part of a ninth treaty.

The Single Convention has the advantage of bringing together in a single new document scattered treaties dating back to 1912. In addition, it has other advantages. The Single Convention has several valuable provisions that are not found in any prior international agreement. For example, under the Protocol of 1953 each producing country must establish a national agency to supervise and control the cultivation of the opium poppy, take possession of harvests, maintain

stocks, and deal in exports and imports. The Single Convention would extend this to the coca bush (the source of cocaine) and to the cannabis plant (the source of marihuana). The Single Convention would prohibit cultivation of the opium poppy, the coca bush, and the cannabis plant by a party when, in its opinion, prohibition is the most suitable way of protecting the public health and welfare and of preventing the diversion of these drugs to the illicit traffic. The Single Convention would establish as a special category the most noxious and potentially harmful drugs (notably heroin and marihuana), whose manufacture, importation, exportation, and distribution, except for medical and scientific purposes, can be prohibited by a party when, in its opinion, prohibition is the appropriate method of control. The Single Convention would state the desirability of establishing adequate facilities for the treatment of drug addicts. These new provisions are valuable as statements of international goals even when they leave the final determination on the action to be taken to the unilateral opinion of a signatory country.

Unfortunately, the Single Convention would seriously weaken the limitations on opium production established by the Protocol of 1953. The Protocol limits the production of opium for exportation to a small, closed list of specified countries, and it establishes limitations on the maximum opium stocks each signatory country may hold at the end of a calendar year. Under the Single Convention, on the other hand, any country which had exported its own opium between 1951 and 1960 would be permitted to continue exportation and any other country would be permitted to export up to five tons of opium annually. In addition, the Single Convention omits the following other control provisions of the Protocol of 1953: The requirement that each signatory country estimate annually the extent of its territory devoted to the production of opium poppies and the amount of opium to be harvested; the provision that the Permanent Central Opium Board, which is an international board, may, with the consent of the signatory country concerned, make inquiries into local opium matters; and the provision that the Permanent Central Opium Board may impose an embargo on the importation of opium from, and the exportation of opium to, a signatory country where the Board finds that the signatory country is failing to carry out the provisions of the Protocol and is thereby seriously impeding narcotics control in its territory.

Today the United States is the principal target of the illicit international traffic in narcotic drugs, and the crux of any international treaty for this country should be its controls on the cultivation and production of opium.

The Commission recommends that the United States oppose, in its present form, ratification of the Single Convention on Narcotic Drugs, 1961, until there is a correction of those sections which

weaken the control and limitation of world opium cultivation and production as established in the Protocol of 1953.

While the Single Convention has the merit of being a codifying document and has some admirable new features, its weakening of the limitations and controls on world opium cultivation and production which have been established by the Protocol of 1953 constitutes a crucial defect.

EXHIBIT III

RECOMMENDED TRANSFERS OF EXECUTIVE FUNCTIONS

★ The investigation of the illicit traffic in narcotics and marihuana and of the illicit traffic in dangerous drugs will be handled together.

VI

TREATMENT

Services and Facilities

The present lack of comprehensive technical knowledge makes it impossible at this time to make any definitive recommendations about treatment. No accepted satisfactory course of treatment has yet been established. Research is still seeking an effective therapy. Nevertheless, some general principles of treatment have emerged, and they are presented here to make available some of the findings of the Commission's study. But long-range recommendations on treatment must await the results of more comprehensive research.

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.

Assistance in various forms—principally technical and financial—should be arranged for programs initiated by state and municipal governments or by private organizations. Before these suggestions are examined further, some general discussion of the treatment problem is necessary.

Accepted medical procedures for treating addicts include detoxification, that is, withdrawal from the drug. Abrupt withdrawal, the so-called "cold turkey" treatment, is very painful and can be dangerous. The addict experiences a range of symptoms—nausea, watering of the eyes, muscle spasms in the stomach and legs, hot and cold flashes—as the central nervous system adjusts to withdrawal. In barbiturate withdrawal, convulsions and delirium tremens may occur. In both barbiturate and opiate detoxification, abrupt withdrawal has sometimes been fatal.

According to current medical opinion, the most humane method is to bring about withdrawal by a gradual reduction of dosage. In opiate cases, the synthetic methadone is usually substituted for the addict's drug of choice, and complete withdrawal takes a week or two in most cases. In barbiturate withdrawal, pentobarbital is generally used, and withdrawal takes days to weeks. It is believed that withdrawal can best be accomplished in a drug-free environ-

ment where the patient cannot illegally obtain additional drugs. Few addicts under withdrawal will resist the attempt to supplement their reduced doses if other drugs are available. Thus the place of withdrawal should best be a treatment center, with medical services available to cope with the physical distress that may arise during detoxification. Such a center does not necessarily have to be a separate, self-contained unit.

Some experts believe that withdrawal is best accomplished in the psychiatric ward of a general hospital. Most drug addicts suffer from personality disturbances which do not fall into simple categories, but cover a wide range of psychiatric disorders. During withdrawal the patient may become hostile and demanding and behave irrationally and impulsively. Accordingly, he is best controlled by a staff trained in the management of psychiatric patients. Moreover, the psychiatrist's insight is of great value.

After withdrawal, the slow process of rehabilitation begins. A special treatment center, such as a hospital or institutional facility, may be used for the first steps. An addict whose drug has just been withdrawn should not have social contact with another addict taking methadone or pentobarbital under withdrawal. Any proximity to persons taking drugs may enhance the addict's sense of deprivation and compound the difficulty of dealing with him.

The program following detoxification must provide many rehabilitative services—medical, physical, vocational, and educational. Initial treatment can do little more than provide the addict with a sense that he is being given firm support. Lasting change may come only after long therapy, principally psychiatric.

The addict should remain at the treatment center for several months before attempting a return to the community. Such a return should be made in stages. Short visits, a halfway house, a work camp, or a day-night hospital may be useful if they can provide the addict with social, therapeutic, and vocational services to give him controlled contacts with his community. Return under any conditions poses difficulties. The former addict is usually jobless. He must once again face the same stresses which originally turned him to drugs. The danger of relapse is great. The released addict should be closely supervised by a specially trained person, whose caseload is small enough to ensure proper supervision.

The non-addict drug abuser poses different problems. For him there is little need for detoxification, but beyond this no other generalizations can be made. The treatment and rehabilitation services and facilities necessary in each case depend on the individual, the type of drug abuse, its virulence and its causes. But it is essential that his predisposition be detected early enough to bring about appropriate treatment before he turns to addicting drugs.

From the Commission's review, four observations emerge:

1. The drug abuser, both the addict and the non-addict, cannot be cured simply by withdrawal. His hold on abstinence will be tenuous, particularly in the case of the addict. To assume a responsible role in society, he must be led by stages through a long and difficult process of treatment. The confirmed drug abuser may relapse more than once, as in a recurrent illness, but relapse should not be taken as an indication that he cannot be rehabilitated. It may well be that treatment cannot create a mature adult out of the confirmed drug abuser. But it is clear that without prolonged extensive after-care following withdrawal, there is little hope that total abstinence will ever be attained. On the basis of present evidence, the confirmed drug abuser must be brought into a rehabilitation program wherever possible.

2. The services and facilities for the treatment and rehabilitation of the drug abuser should be in or near his own community. If the goal of treatment is that he learn to make his way in the community, then the services that support him should be readily available in his neighborhood.

3. The treatment and rehabilitation of the drug abuser requires an interdisciplinary approach. Physicians, including psychiatrists, can play a large role in treatment, but treatment and rehabilitation are more than a medical problem. The psychologist, the lawyer, the penologist, the teacher, the criminologist, the clergyman, the social worker, and others all have roles to play.

4. For the purpose of considering methods of treatment, drug addicts and habitual users fall into certain broad categories:

(*a*) Those confined and subject to prison discipline. The necessities of life in penal institutions require that they be taken off their drugs, and many want to be taken off. Here, in the custody and under the control of government officials, is a large group of drug abusers.

(*b*) Those who detest their drug habit and hail any opportunity to be rid of it. These people welcome therapy which produces relief and will cooperate willingly. Their prime difficulty is an inability to combat the precipitating causes of their affliction following return to community life. Assistance from friendly interested individuals and organizations can be of value here. It should be noted that the preventive effectiveness of this type of help is great.

(*c*) Those drug users who can be rehabilitated, but who do not wish to be rehabilitated except during brief intervals of remorse or distress at their plight. This is a most difficult category and includes those who succumb to the habit because of mental defects, personal maladjustment, or economic or social conditions. No effective treatment of these people is known. They are the ones for whom halfway houses, part-time release, supervised probation, and similar measures should

be tried. The rehabilitation of these people constitutes a vast social problem.

(*d*) The "incurables." These are the people whose dependence upon drugs has gone so far and become so fixed as to be impossible to change except at severe risk to life or health. It also includes those whose habit has been of such long duration that the education of the victim or his training to pursue a useful vocation has become impossible. What to do with these people is a difficult moral and social problem.

The Medical Use of Narcotic Drugs

Since the passage of the Harrison Act in 1914, the federal narcotics laws have expressly permitted a physician to prescribe narcotic drugs for a patient in the course of "professional practice only" and for "legitimate medical uses" and "legitimate medical purposes." Under this statutory language there is no doubt that a physician may prescribe narcotic drugs for a patient suffering acute pain or from a painful and incurable disease. But a controversy has existed for fifty years over the extent to which narcotic drugs may be administered to an addict solely because he is an addict.

During the first ten years following enactment of the Harrison Act, the Supreme Court affirmed several convictions under the Act involving the indiscriminate prescribing of narcotic drugs for addicts. In 1925, however, in *Linder* v. *United States*, 268 U.S. 5, the Court indicated that the dispensing of narcotic drugs by a physician for the purpose of relieving conditions incident to addiction was not in every instance a violation of the Act. The case concerned a doctor who had given one tablet of morphine and three tablets of cocaine to an addict. The Harrison Act, said the Court, "says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purpose 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."

The regulations of the Bureau of Narcotics, however, do not seem to be in accord with that language. The current regulations state: "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 [Harrison] Act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law."*

*Code of Federal Regulations, Title 26, Section 151.392.

The practicing physician has thus been confused as to when he may prescribe narcotic drugs for an addict. Out of a fear of prosecution many physicians refuse to use narcotics in the treatment of addicts except occasionally in a withdrawal regimen lasting no longer than a few weeks. In most instances they shun addicts as patients.

Drug abuse is not a uniform problem throughout the country, and even in the areas of highest incidence few medical practitioners come into contact with the afflicted. It is estimated that most medical practitioners never see a habitual drug abuser. Nevertheless, spokesmen for the profession have a responsibility to speak for the physicians who are concerned.

The Commission recommends that federal regulations be amended to reflect the general principle that the definition of legitimate medical use of narcotic drugs and legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession.

The American Medical Association (AMA) has for many years had committees on this subject. This Commission requested the AMA on January 30th, 1963, and the National Academy of Sciences-National Research Council (NRC) on February 20, 1963, to submit a joint statement as to what, in their opinion, constitutes the legitimate medical treatment of a narcotic addict, both in and out of institutions. In June 1963, the two organizations, acting through their appropriate committees, submitted a joint statement in response to the Commission's request. The statement has been adopted by the Board of Trustees and the House of Delegates of the AMA.*

The joint statement points out that narcotic drugs may be properly administered over prolonged periods to patients suffering chronic painful diseases and to patients in terminal conditions. It cautions that in such cases the physician should not act alone, but should consult other medical opinion. It also cautions the physician to maintain adequate records and guard against any diversion to illicit channels. The statement advises that narcotics may also be administered to aged and infirm addicts and to severely ill addicts when abrupt withdrawal might be dangerous to life. Here, too, the physician should consult other medical opinion, maintain adequate records, and guard against diversion.

The statement opposes abrupt withdrawal and favors the administration of limited quantities of methadone, a substitute narcotic, in constantly reduced dosage during gradual withdrawal. It advises that withdrawal be carried out in a drug-free institutional setting.

The statement considers ambulatory withdrawal medically unsound as a general policy at this time. While it says that ambulatory with-

*The full text of the statement appears in the Appendix of this Report. It has also been reprinted in the Journal of the American Medical Association, September 21, 1963, CLXXXV, 976–982.

drawal may be proper in exceptional individual cases, it should be attempted only where the physician has special skill and training in the management of addicts. It cautions that even in such cases the physician should dispense only a day's supply of oral methadone at a time, and no more than enough to reduce the distress of withdrawal to a mild level. While the AMA and the NRC do not completely close the door to ambulatory withdrawal, they do oppose clinics for this purpose.

These organizations also hold that narcotics may be dispensed to an addict awaiting admission to a narcotics withdrawal facility. The physician should see the addict daily and dispense no more than a day's supply of oral methadone at a time. Such a period should last no more than ten days to two weeks.

The most controversial subject with which the joint statement deals is the oft-heard proposal that physicians be permitted to maintain addicts on drugs. According to this proposal, the drugs would be available through legal channels at relatively low prices. Those favoring the proposal argue that addicts would not have to turn to illicit sources for their drugs, and without buyers, the illicit traffic would dry up. Moreover, addicts would not turn to crime to support an expensive drug habit and could lead moderately productive lives.

The AMA and the NRC both state—on the basis of present knowledge—that the continuous administration of maintenance doses to addicts as treatment is medically unsound. The preponderance of evidence presented by experts at the first White House Conference on Narcotic and Drug Abuse and to this Commission confirms this position.

There is no certainty that an addict can be maintained at a stable level. A confirmed addict builds up a tolerance to his drug, and to offset the effects of withdrawal the dosage must be continually increased. Moreover, it would be an unwarranted admission of failure to resort to maintenance doses when research is just beginning to indicate more promising developments in the treatment and rehabilitation of addicts and habitual users.

The joint AMA–NRC statement affirms that further research is needed, pointing out that current concepts of what constitutes ethical medical practice in the treatment of narcotic addicts will be subject to continual revision as the findings of research become known. The Commission endorses this call for further research. It strongly believes that properly designed experiments should be initiated to explore whether ambulatory clinics for the dispensing of maintenance doses to addicts are feasible. Ambulatory clinics were tried briefly in the early 1920's, but they maintained inadequate controls over the drugs that were dispensed. Because of inadequate supervision they were discontinued without any conclusive findings being obtained. In addition, there has never been carefully controlled research to

determine whether addicts can or cannot be withdrawn from drugs by an outpatient facility.

The joint AMA–NRC statement makes clear that many restrictions on the use of narcotics in regular clinical practice may be relaxed in the conduct of a research project. A psychiatrist treating addicts may wish to experiment with maintaining an addict over a course of months until a positive working relationship can be established. The statement recognizes that the psychiatrist on a research project should be able to do so, provided he remains within the bounds of proper medical ethics.

The experience of Great Britain with its addicts has been cited—mistakenly, in the opinion of the Commission—to support the feasibility of maintaining the American addict. Under the so-called "British system," a physician may prescribe narcotics to an addict as part of a process of gradual withdrawal, or when an addict cannot safely be detoxified because of the severity of the resulting symptoms, or when the patient is considered to be capable of leading a useful life only when a minimum dose is regularly administered.

Under that "system," as this Commission understands it, narcotics may not be prescribed or dispensed solely to gratify an addiction. Before a drug addict may be so maintained, every effort must have been made to cure the addiction. Great Britain has no maintenance clinics, and each case is handled by the individual practitioner. The point of dissimilarity between the "British system" and the American practice lies in the authority taken by the individual British physician to treat the addict as he deems best in his medical judgment.

The greater freedom of the British physician reflects the pattern of addiction in Great Britain. Many British addicts unlike their American counterparts, would be classified as "medical addicts." Medical addiction occurs when the drug is originally prescribed in the course of medical treatment for a physical or mental illness, and the addict cannot thereafter abandon it. The British addict appears to have sufficient motivation to pursue an ordinary life.

The American addict is quite different. In most instances, he has little motivation and his vocational and economic handicaps limit his ability to lead a normal life. There is no reason to believe that his dosage level can be stabilized. It is often pointed out that Great Britain has a few drug addicts. In 1962 the United Kingdom reported to the United Nations that it had 532 known addicts. But the reason appears to lie outside the "British system." In the view of most experts, this low incidence of addition is due to the British abhorrence of narcotic drugs and the lack of a cultural susceptibility to drug-taking. With the recent influx of other cultural groups into Great Britain, the number of drug offenses, particularly marihuana, has almost doubled. In 1961, there was a total of 357 convictions for drug offenses; in 1962, there were 675 convictions.

Finally, the joint AMA–NRC statement advocates the establishment of a national medical group to keep current a code of ethical medical practice with regard to narcotics and narcotic addiction and to act in an advisory capacity to the federal authorities on this matter. The Commission favors the establishment of such a group and its designation to advise the proper federal authorities on ethical medical practice in the use of narcotic drugs and in the treatment of narcotic addicts. In individual cases in which a physician is alleged to have prescribed or dispensed narcotic drugs in violation of federal law, the Commission is of the view that the federal authorities should seek the assistance and collaboration of the appropriate state medical body.

The Role of State and Local Governments

Under our federal system, the public health and welfare are primarily the responsibility of state and local governments. The federal government has a definite role to play, but the initiative and final judgment as to courses of action must come from the states and municipalities themselves. The treatment of the drug abuser falls within this classic mold. But even apart from constitutional considerations, the treatment of the drug abuser must lie primarily with state and local governments since an effective program of rehabilitation must, of necessity, rest upon services in the community.

Until recent years there have been few state and local programs seeking the treatment and rehabilitation of the drug abuser. This delay in launching long-range programs was due in some extent to confusion over which agency should administer the program, as well as a feeling that the primary emphasis should be on the control of the illicit traffic.

A number of experimental efforts are now underway. California and New York offer particularly noteworthy examples. In 1961, California initiated a program for the civil commitment of persons who are addicted to narcotics or are in imminent danger of becoming addicted. The program will be discussed in detail in a succeeding chapter, but it should be noted here that the program provides extensive services for the rehabilitation of the narcotic abuser.

California has also instituted a program for the control and treatment of narcotic abusers who have been convicted of a felony (the felony need not be a narcotics offense), sentenced, and paroled after serving a portion of the sentence. The program, initiated in October 1959, is known as the Narcotic Treatment-Control Project. It is administered by the State Department of Corrections. The Department's institutional facilities are used for detoxification, where necessary, and initial rehabilitation. When a prisoner is eligible for parole, his case is given careful screening to determine whether he should be released. Those who are paroled are assigned to specially

trained parole officers. Nalline tests are administered to determine whether or not the parolee has relapsed.

If relapse occurs, he is returned to an institution for further treatment. This need not involve a revocation of parole, however, and the individual is usually restored to parole in about 90 days. A halfway house is operated by the Department in East Los Angeles, a neighborhood in which addiction is of high incidence, to serve as an intermediate phase of supervision between the institution and the community for a limited number of parolees.

Action research and evaluation were built into the Narcotic Treatment-Control Project. The research deals with the nature of addiction, the characteristics of addicts, and methods of prevention. It also deals with the efficacy of the project as a whole and the specific techniques and procedures used. On September 30, 1963, the Narcotic Treatment-Control Project began its fifth year of operation. There were 833 parolees under the project on that date.

In New York, there are a variety of new programs—state and municipal. The state has enacted a law for the civil commitment of narcotic addicts, which will be discussed with the California law in a succeeding chapter. The State Division of Parole has pioneered in studying the efficacy of small caseloads for parole officers supervising former addicts. In September 1963, the Appellate Division of the State Supreme Court, with financial assistance from the National Institute of Mental Health, opened a halfway house for the treatment of a selected number of former addicts on probation in Brooklyn and on Staten Island.

In New York City, a narcotic addiction treatment, research, and training program has been established by municipal authorities at Metropolitan General Hospital. The program is being carried out in conjunction with New York Medical College and is concerned with defining and developing the extensive rehabilitative services needed by the addict after detoxification.

The New York City Department of Health, with the cooperation of the New York City Community Mental Health Board and the National Institute of Mental Health, has recently instituted a project to explore the role of local public health agencies in dealing with the addict and his family. The new position of Narcotics Coordinator, to coordinate the activities of the various municipal agencies concerned with narcotic abuse, has been created in the New York City Department of Health. This Department has also established four "Rehabilitation Centers," which are strategically located to encourage former drug abusers under extra-hospital care to come for assistance and referral services.

Detroit and Chicago have experimented with rehabilitation services for addicts who voluntarily seek help, and Detroit is currently planning a community control program that will provide extensive

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services. The Maryland State Hospital at Spring Grove operates a pilot project focused on developing the self-confidence of the addict to meet the challenges of society better when he returns to the community.

There are many continuing problems faced by the states and municipalities. Research is still trying to define accurately what is a "cure" and to determine who is an "incurable addict." As research continues, it may reveal that certain addicts may never benefit from any type of rehabilitation program and will forever remain parasites upon society.

States with a drug abuse problem of low intensity face a special problem. It may be prohibitively expensive for such states to establish special rehabilitation facilities and programs. These states might explore with neighboring states the feasibility of establishing regional facilities.

Community Resources

In the Commission's view, drug abuse as a social problem can be solved only by mobilizing all the resources of the community. It cannot be solved alone by those professionally involved. The ultimate solution of drug abuse must lie in an ultimate solution of the underlying social ills. This Commission feels that any progress will require full community awareness and understanding and a mutual desire by all community groups to become involved.

Private agencies have undertaken to help treat and rehabilitate the drug abuser. Some assist the addict through withdrawal or assist him to obtain admittance to treatment facilities. Others help in vocational rehabilitation or job placement or provide temporary financial assistance. Some offer guidance, counseling, or psychotherapy. They operate solely in response to voluntary requests and with the voluntary cooperation of the drug abuser. While this may limit the number they reach, their services have the valuable quality of being divorced from any punitive or criminal connotation.

These private agencies have varied sponsorship. They are established by religious groups, family and social welfare agencies, community councils, settlement houses, juvenile delinquency prevention projects, and often by individuals.

One of the oldest such voluntary agencies is the East Harlem Protestant Parish Narcotics Committee in New York City, which has provided a wide variety of services to more than 2,000 addicts. One of the newest is the Village Aid and Service Center in the Greenwich Village section of New York City, which offers addicts the opportunity to discuss their problems, counsels them, and refers them wherever possible to withdrawal and treatment facilities.

An organization that relies primarily on self-help is Narcotics Anonymous. It was begun in 1948 and is modeled on Alcoholics

Anonymous. Narcotics Anonymous holds meetings at which former addicts gather to discuss mutual problems. For more extensive treatment services it serves as a referral agency.

A similar approach, in that it involves a mutual help program conducted by addicts, has been adopted by Synanon, an independent organization which originated in Santa Monica, California. Synanon operates residential facilities where it offers leaderless group psychotherapy, vocational training, a sheltered workshop, and other rehabilitative activities in a drug-free environment.

In Stamford, Connecticut, a Narcotics Addiction Service Center has been established on a pilot project basis with the aid of funds from the National Institute of Mental Health. This Center provides some treatment services and arranges for treatment elsewhere if its own services are not sufficient.

There are other groups that have developed in various communities in response to specific situations and needs. Many of these groups represent the work of highly dedicated persons. The majority have no funds and are unsponsored. The pressures of providing services have been such that it has seldom been possible for such groups to engage in the kind of scientific reporting that is traditional in more established organizations.

The work of these and other private groups has not been scientifically evaluated, and the Commission cannot speak with authority on the value of their contribution. On the basis of the empirical evidence, however, it appears that many often achieve good results. Such activities should be encouraged and the establishment of additional projects stimulated. But all should provide for a carefully planned, built-in evaluation to determine the particular merits or disadvantages of their efforts.

The Role of the Federal Government

The federal government renders some assistance to state and local governments and to private nonprofit organizations for the development, establishment, and maintenance of treatment and rehabilitation services for drug abusers.

1. Under the Public Health Service Act, the government makes grants to the states for general health purposes, to assist local public health organizations in strengthening their staff and services. It also makes grants to the states for mental health services. These grants may be used to provide and improve services for the treatment of the drug abuser. The Act also authorizes financial and technical assistance for research and demonstration projects to develop treatment and rehabilitation programs or to develop special services and techniques for these programs.

2. Under the Vocational Rehabilitation Act, the government makes grants to the states for the support of vocational rehabilitation services

for the physically and mentally disabled, and it is authorized to make special grants for the improvement and extension of these services.

3. Under the Wagner-Peyser Act, the government makes grants to the states to support employment services for the physically and mentally handicapped.

Both the vocational rehabilitation program and the employment services program, while aimed at the mentally disabled and handicapped generally, may also be used to help the drug abuser. But all these statutes have only a limited impact on drug abuse.

The Commission recommends that legislation be designed to provide authority for the federal government to render direct financial and technical assistance to state governments (singly or acting together on a regional basis), to local governments, and to private nonprofit organizations for the establishment, maintenance, and expansion of broad treatment and rehabilitation programs and the training of staff and personnel to staff and operate the programs.

Proposals have been made for federal assistance to state and local governments for the construction of hospitals to specialize in the treatment of narcotic addicts. The Commission is opposed to the construction of new single-purpose hospitals for such special treatment. For the treatment of the addict after detoxification, and for the initial treatment of the non-addicted drug abuser, a specialized hospital is not a necessity. There must be a center for continuing treatment where the addict may remain for many months, but it need not be a specialized hospital. In the view of the Commission, the construction cost of single purpose hospitals would be an unnecessary federal expenditure.

The Commission recommends federal assistance to state governments, acting singly or on a regional basis, and to local governments for the construction of non-hospital treatment centers for narcotic and dangerous drug abusers and for treatment units in state and local hospitals.

Federal assistance should also be available where it is more feasible to modernize and refurbish an existing hospital facility or to construct a wing to an existing hospital than to construct a new non-hospital center. Neither the Hill-Burton Act, which authorizes federal assistance to the states for the construction of hospitals, nor Public Law 88-164, enacted on October 31, 1963, and authorizing federal assistance to the states for the construction of community mental health centers, provides sufficient authority to carry out the Commission's intention. New legislation will be needed.

Those state or local governments or private nonprofit organizations seeking assistance for a particular project should be required

to file formal application for assistance. Grants should be awarded on the approval of the Surgeon General. In developing the standards that will govern the making of grant awards, the Surgeon General should seek outside as well as internal advice. The Department of Health, Education, and Welfare should generally assist would-be applicants in formulating projects and in preparing applications for grants.

The federal government treats some narcotic addicts at the Public Health Service hospitals in Lexington, Kentucky, and Fort Worth, Texas. The addiction treatment centers at these hospitals were originally established for federal prisoners, but at present they also accept addicts voluntarily seeking treatment. The hospitals withdraw the addict from his drug and provide a rehabilitation program which stresses psychotherapy and vocational training. There are at the present time between 800 and 900 federal prisoners in the two Public Health Service hospitals. Some may remain there for their entire sentences, while others are ultimately sent to an institution of the Bureau of Prisons. Since the federal government cannot hold them involuntarily, the voluntary patient may leave the hospital whenever he desires without having completed the recommended course of treatment. There is no followup care, supervision, and help that the Public Health Service hospitals can provide in the community. Past history indicates that most voluntary patients do not remain for the recommended course of treatment. They leave the hospital before achieving adequate rehabilitation and usually relapse. For them, treatment at a Public Health Service hospital becomes in essence a revolving-door process.

The Commission recommends that the Public Health Service hospitals in Lexington, Kentucky, and Fort Worth, Texas, accept voluntary patients only for purposes of research study in the future.

Treatment of voluntary patients should be the responsibility of the drug abuser's state and community. The treatment of narcotic addicts by the Public Health Service hospitals should be limited to federal offenders. The activities of these hospitals should be directed primarily towards research. This research should not be confined to narcotic addiction alone but should extend into all areas of drug abuse.

At present there are in the federal penal system approximately 2,150 federal prisoners who have been narcotic or marihuana abusers. Some have been convicted of offenses under the federal narcotics or marihuana laws. Although precise statistics are unavailable, if all psychotoxic drugs are considered, the total number of former drug abusers in the federal prisons would obviously be substantially higher. Certain prisoners who have been drug abusers receive special psychotherapy and counseling. But these are individual cases and are not

part of a comprehensive treatment program organized for all prisoners having a history of drug abuse. The Bureau of Prisons is aware of this situation, and it has recently begun construction of a psychiatric hospital for federal prisoners at Butner, North Carolina, which will treat drug abusers along with other psychiatric patients. Efforts to meet the special needs of this category of prisoners should be expanded.

The Commission recommends that the Bureau of Prisons establish a special treatment program for confirmed narcotic and drug abusers within the federal prison system.

The special program should offer individual and group psychotherapy, counseling, and vocational training, going beyond the regular prison rehabilitation program and dealing with the special needs of the drug abuser.

As community rehabilitation programs prove themselves, federal prisoners who are given probation conditioned on their participation in the rehabilitation program of a Public Health Service hospital could, upon completion of the program, be released on the further condition that they enter a community program. Federal prisoners eligible for parole could be released on similar conditions. Such a probationer or parolee would be under the supervision of a federal probation-parole officer, and the federal government could reimburse the community program for the therapy and training provided. If the Commission's recommendation for the amendment of the present penalty provisions of the federal narcotics and marihuana laws is put into effect, it will have many desirable effects: indeterminate sentences, probation, and parole would become more widely available, and a treatment and rehabilitation program that begins in a Public Health Service hospital or in a Bureau of Prisons facility and goes on to include a local program would reach and benefit a substantial number of federal offenders who have been confirmed drug abusers.

VII

CIVIL COMMITMENT

Probably the most far-reaching new development has been the enactment by California and New York of laws for the civil commitment of narcotic addicts. The California law was enacted and became effective in 1961 and was amended in July 1963; the New York law was enacted in 1962 and became fully effective in January 1963.

Civil commitment is a legal mechanism utilized in lieu of a criminal commitment to ensure control over addicts and potential addicts during rehabilitation, first in an institution, later perhaps in a halfway house, still later in the community under the close supervision of a probation or parole officer.

The commitment is to a program, not necessarily to a place. Quite obviously, however, it is worthwhile only if it provides a means to rehabilitate the addict. Without a long regimen of therapy, training, and education, and without skilled and understanding physicians, psychiatrists, teachers, social workers, and probation and parole officers, civil commitment becomes but a euphemism for imprisonment. The California and New York programs, promising as they appear, are still too new for definitive evaluation. Both should be closely observed over the next few years by all concerned with the rehabilitation of the drug abuser.

The California Program

The present California law provides for the civil commitment of persons who are addicted to narcotics or who are in imminent danger of becoming addicted. The law distinguishes three categories of persons who may be civilly committed:

(1) persons convicted of misdemeanors,

(2) persons convicted of felonies other than crimes of violence, and

(3) persons not charged with crimes who report to the district attorney their belief that they are, or are about to become, addicted; or who are reported to the district attorney by relatives, friends, or others.

In the case of those convicted of a misdemeanor or felony, where the judge has reason to believe that the defendant may come under the civil commitment law, further criminal proceedings are suspended

after a conviction or plea of guilty, a petition is filed, and a judicial hearing is held. If it is found that the defendant is addicted or in imminent danger of becoming addicted, the court having jurisdiction over the commitment proceedings may commit him to the Director of the State Department of Corrections for a maximum period of seven years; on a finding that he is not, the court will return him to the court having jurisdiction over the criminal proceedings for sentencing. If at any time after 60 days the Director of Corrections concludes that a committed defendant is not a fit subject for treatment, he is returned to the court having jurisdiction over the criminal proceedings for further disposition.

In the case of those who are not charged with the commission of a crime, the court having jurisdiction over the commitment proceedings may, after a medical examination and a judicial hearing, deny the petition and discharge the person, or it may order him committed to the Director of Corrections. If the person voluntarily sought commitment, the maximum period of commitment is two and one-half years. If the commitment is involuntary, the maximum period is seven years. The Director of Corrections may discharge him if he concludes at any time after 60 days that he is not a fit subject for the program.

All those who are committed under this law are sent as patients to the California Rehabilitation Center in Corona, California, administered by the Department of Corrections. At the Rehabilitation Center, the patient enters upon a group psychotherapy program, and participates in a remedial educational program, vocational training, and other rehabilitative activities. He must remain at the Rehabilitation Center at least six months before he is eligible for release as an outpatient. After release, he is kept under close supervision by specially trained parole officers. Nalline tests are periodically administered to detect any relapse. It if becomes necessary, he may be returned to the Rehabilitation Center for further treatment and again released under supervision. If a person who has been committed abstains from the use of narcotics for three consecutive years as an outpatient, he may be discharged from the rehabilitation program. If his commitment followed a criminal conviction, the criminal proceedings may be dismissed after his discharge. If a convicted person is not discharged prior to the expiration of his term of commitment, he is returned for further disposition to the court having jurisdiction over the commitment proceedings. The court may extend his commitment for a period not to exceed three years or it may return him to the court having jurisdiction over the original criminal proceedings for resumption of those proceedings.

The California program is reaching a significant number of narcotic abusers. On September 30, 1963, there were 1,121 persons at the Rehabilitation Center and 601 outpatients. The facilities of the pro-

gram will be broadened. Additional halfway houses for persons under civil commitment are planned for the northern and southern sections of the state. Finally, it should be noted that research on narcotic abuse and on the efficacy of the civil commitment program is gradually being built into the program as an integral part of it.

The New York Program

The New York civil commitment law, popularly known as the Metcalf-Volker Act, provides, like the California law, for both inpatient and outpatient treatment. But where the California law lodges the responsibility for the establishment and operation of the treatment program with the Director of Corrections, the New York law lodges it with the Commissioner of the State Department of Mental Hygiene.

Under the New York law there are three categories of addicts eligible for admission to the program. The process of commitment, the length of time for which an addict can be held, and the procedures of the program, differ with respect to each category.

The largest category covers narcotic addicts who have been arrested for narcotic law violations or other criminal offenses, except certain serious crimes, but have not yet been convicted. There must be no extensive history of prior felonies or of failures under prior commitments, and there must be no objection from the district attorney.

The addict offender must request commitment within 10 days of his arrest. If he does, he may be committed for treatment. The Commissioner of Mental Hygiene must be willing to accept him, and there must be adequate treatment facilities, although treatment need not be wholly institutional. The total period of commitment, however, may not exceed three years, whether spent in a treatment facility or in the community under supervision. If the addict offender is committed, prosecution of the original criminal charge is held in abeyance. If in the course of treatment it is found that the addict offender is unresponsive or uncooperative, he is returned to the court. If he completes the treatment program successfully, he is discharged and the criminal charge is dismissed.

Another category includes narcotic addicts who voluntarily commit themselves to a treatment facility or, if under the age of 21, are committed on application by their next of kin. They may be held without a judicial hearing and given treatment for a period of at least 45 days, and longer if they consent. Where there has been a judicial hearing, they may be held and given treatment for a period of not more than a year. The addict may be discharged before the expiration of a year if he has recovered or if he is not amenable to treatment.

The third category covers addicts convicted of a crime, usually offenders placed on probation by the court on condition that they

submit to treatment. Again, the Commissioner of Mental Hygiene must be willing to accept the addict for treatment, and adequate facilities must be available. The treatment program need not be wholly institutional and may include outpatient care in the community under supervision. The entire course of treatment cannot exceed the period of probation imposed by the court. The addict may be returned to the court before expiration of the probationary period if he has recovered or if, on the other hand, he is unresponsive or uncooperative.

The Department of Mental Hygiene has established special treatment units for committed addicts in six state hospitals: one in New York City, three within 70 miles of New York City, and two in upstate New York. These units have a total capacity of 455 beds. Local authorities, especially in the large cities, are expected to provide supplementary facilities for detoxification, and, in some cases, facilities for short-term treatment.

When an addict is released from inpatient care and treatment in a state hospital unit and returned to the community on an outpatient basis, he is required to report periodically to a facility designated by the Commissioner of Mental Hygiene as suitable to supervise a treatment program for former addicts. Such facilities may be under public or private auspices. In the New York City area, the State Department of Mental Hygiene operates aftercare clinics on Wards Island and on 17th Street. Throughout the outpatient period, addicts are subject to home visits and to reasonable regulation of their conduct by the aftercare facility. They must submit to medical treatment and nalline tests to detect any relapse. The New York civil commitment law came into effect on January 1, 1963. On October 23, 1963, the program had 370 inpatients in the various state hospital treatment units and 285 outpatients.

A Federal Program

From time to time proposals have been made for the civil commitment of narcotic and marihuana abusers by the federal government. The details of these proposals vary as to who may be committed and under what conditions and standards. It appears, however, that the federal government has only a limited power of civil commitment. Where the narcotic or marihuana abuser has committed no federal crime, there is not statute conferring federal jurisdiction over his person and therefore no federal right to commit him. Only where he is charged with the commission of a federal crime is there federal jurisdiction over his person.

It is the prevailing view of the Department of Justice that a person charged with the commission of a federal offense may constitutionally be committed for treatment in lieu of prosecution as under the New York civil commitment law. The Commission does not believe,

however, that the New York plan should be adopted as the federal pattern. A serious problem is raised by the provision in the New York law that an addict offender who has been civilly committed in lieu of being prosecuted, and who proves unresponsive to or uncooperative in treatment, may be returned to the court for prosecution of the original charge. If he is returned to the court after a considerable lapse of time, much of the evidence on his behalf may have dissipated, and there is no assurance that he will receive as fair a trial as he would have if the charge had been promptly prosecuted. Although under the New York plan, the addict must consent to this procedure circumstances may arise in which it could be contended that the addict, for various reasons, did not effectively waive his constitutional rights. It would be best to avoid these problems by proceeding immediately to have guilt or innocence judicially determined at the outset, as under the California law.

If a narcotic or marihuana abuser is convicted of a federal crime, he may under present law be placed in the treatment and rehabilitation program which this report has recommended be established for federal prisoners.

The Commission recommends that a federal civil commitment statute be enacted to provide an alternative method of handling the federally convicted offender who is a narcotic or marihuana user.

As the Commission views it, a federal civil commitment statute would authorize a judge of a United States District Court to commit civilly a narcotic or marihuana abuser convicted of a federal crime (except a crime involving smuggling or trafficking in narcotic drugs in large quantities or the selling of narcotic drugs for resale, or a crime of violence) where the judge determines that the defendant's offense is related to his abuse of drugs and that there are reasonable grounds for belief that the defendant can be rehabilitated by treatment. The authority to commit would be wholly discretionary with the judge, and the judge would solicit and act upon expert advice in making a determination under the statute.

Commitment under the statute would be to the care and custody of the Attorney General. In making the commitment, the judge would suspend all further criminal proceedings, including the imposition of sentence. The commitment would be for a maximum period of five years, but in no event for a period exceeding the maximum criminal sentence that could have been imposed on the defendant. The actual treatment and rehabilitation program would be administered by the Bureau of Prisons, and it would parallel the program for federal prisoners generally. The Bureau of Prisons might use its existing facilities for some who are civilly committed, might establish special facilities for others, and might turn others over to a Public

Health Service hospital for treatment as research subjects. A person who has been committed would be required to remain in a Bureau of Prisons or Public Health Service facility for a period of at least six months. He could thereafter be released as a parolee upon a determination by the Attorney General, acting on the advice of institutional and parole authorities, that the committed person has made sufficient progress in treatment to warrant his return to the community.

Upon his release, the parolee should be subject to close supervision by a federal probation officer. He should be provided with outpatient treatment services in the community wherever possible, and the federal government should contract for these services where necessary. The parolee should be required to report periodically for tests to determine, to the extent possible, whether he has relapsed to drug abuse. The specific type of test should be left to the determination of the Federal Probation Service. If a parolee relapses, he may be returned to the care and custody of the Attorney General for further treatment until he is again deemed ready to return to the community.

If the Attorney General, acting on the advice of those who have been concerned with his treatment and supervision, determines that a person who has been civilly committed has successfully completed the treatment program, he may discharge him. Upon certification of the discharge to the United States District Court having jurisdiction over the original criminal proceedings, the court shall set aside his conviction.* If the Attorney General determines that a person who has been civilly committed is not responsive to or is uncooperative in treatment, or if the maximum period of commitment expires without successful completion of the treatment program, the Attorney General shall return the person to the court having jurisdiction over the original criminal proceedings for resumption of the proceedings. The court may then impose sentence, but the period spent under commitment and the period of the sentence may not cumulatively exceed the maximum sentence that could have been originally imposed on the defendant.

The Commission advocates the enactment of a federal civil commitment statute and the development of a treatment program under it in the belief that selected addicts may, if they strongly desire to do so, rehabilitate themselves under this form of commitment. A humanitarian consideration, and one of great importance, is that they may thus expunge their criminal conviction and thereby be spared the lifelong stigma of the ex-convict.

*There is an existing analogue in the Federal Youth Corrections Act, United States Code, Title 18, Section 5021. It provides that the conviction of a youth offender who has been committed or placed on probation shall be set aside upon unconditional discharge before expiration of his maximum sentence.

The Commission believes that the statute it is recommending will provide adequate safeguards against unwise decisions or practices. The crucial determinations would be made by the Judiciary and by the Attorney General. They would have available the advice and recommendations of experts. The treatment program and supervision of a committed person would be the responsibility of federal services which have earned high prestige in their fields: the Bureau of Prisons, the Public Health Service, the Board of Parole, and the Probation Service. Where drug abuse is concerned, one does well to consider any new program experimental. The Commission so considers the proposed statute and program, but it believes them to be both justified and desirable.

CONCLUSION

The Commission is mindful that control of the drug abuse problem is a most difficult matter. The smugglers and illicit traffickers are clever and ruthless. We lack considerable knowledge about the causes of drug abuse and how to treat it. Moreover, the drug abuser's personality disturbance, his sense of alienation from society, and his economic and vocational handicaps are profound. But while drug abuse can probably never be wholly eradicated, the Commission believes that it can be arrested and significantly reduced.

In this report the Commission has set forth a comprehensive program of federal action on drug abuse. Federal action alone cannot do the job. State and local governments, private organizations, and the community at large must bring their full resources to bear on the problem. But the federal government has a crucial contribution to make. In the Commission's view, it can best make this contribution by adopting the recommendations contained in this report.

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APPENDIX I

The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts

A Statement of The American Medical Association Council on Mental Health
and
The National Academy of Sciences—National Research Council Committee on Drug Addiction and Narcotics

June 1963

Prepared at the request of The President's Advisory Commission on Narcotic and Drug Abuse

Introduction

1. One of the major points of the President's Ad Hoc Panel (*1*) as presented to the 1962 White House Conference on Narcotic and Drug Abuse was that the statutory and regulatory measures for the control of narcotic drugs are not intended to interfere with administration of narcotic drugs in legitimate medical practice. Such administration is legally and medically sound and is approved by enforcement agencies.

2. The Ad Hoc Report contains a sharp reminder that expressions of prevailing medical opinion have a profound impact not only on medical practice but on regulations (*2*), laws and courts, and that it is the duty of the medical profession to review its expressed opinions regularly in order to assure their current validity.

3. Our two committees* are now charged with the task of preparing such a review of current medical opinion to the end of developing a tentative "code" defining proper ethical medical practice with respect to narcotics and narcotic addicts which reflects the best current opinion. It is the primary purpose of the committees to identify generally accepted broad principles, presenting specific details only where especially indicated, for example:

(1) To correct certain mistaken but widely held impressions.
(2) To emphasize relatively new developments.
(3) To establish a better balance between the emphasis on what can or should be done and what cannot or should not be done.

4. The opening pages of the present report are devoted to a brief historical review of previous documents in this field and an outline of some general data which seems necessary to give the statement an adequate degree of continuity. The main body of the text is presented next and is followed by a summary and appendices composed of material from three of the important supporting documents.

Historical Note

5. In 1921 an AMA committee issued a statement which was, in effect, a definition and a code of medical practice (*3*). It was adopted in 1924 as a resolution by the AMA House of Delegates (*4*) and many federal and state narcotic law enforcement policies were built around it. It read in part:

6. ". . . The only proper and scientific method of treating narcotic drug addiction is under such conditions of control that any administra-

*Named at the close of this report.

tion of any habit-forming narcotic drug must be by or under the direct personal authority of the physician with no chance of any distribution of the drug of addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment."

7. A number of statements have appeared since this original position paper. Among them are the following:

(*a*) A 1952 Report to the AMA Council on Pharmacy and Chemistry (*5*). This statement entitled "What to Do With a Drug Addict" was prepared by the Committee on Drug Addiction and Narcotics of the National Research Council (NRC) with the assistance of Dr. Harris Isbell, Director of the Addiction Research Center at Lexington, Kentucky. The Council on Pharmacy and Chemistry of the AMA authorized its publication.

(*b*) A 1957 Report of the Board of Trustees to the House of Delegates of the American Medical Association (*6*) outlined a series of steps which began in 1954 with a resolution by Dr. Eggston of New York and resulted in the appointment by the AMA Council on Mental Health of a Committee on Narcotic Addiction.

(*c*) A report prepared by the Council on Mental Health, the AMA staff and several physicians well informed on the subject of narcotic addiction (*7*).

(*d*) Certain items prepared in connection with the Karsten Bill of 1959 (*8*).

(*e*) A joint release (*9*) by the American Medical Association (AMA) and the National Research Council (NRC) Committees, approved by the Bureau of Narcotics, retained the essentials of the original 1924 position but indicated the need for development of research designed to gain new knowledge about the prevention of drug addiction and the treatment of addicted persons (Appendix I and Appendix II).

Definition of the Problem

8. For purposes of this document the World Health Organization definition of addiction (*10*) is used but our presentation is limited to the opiate class of drugs, natural and synthetic.

9. Physicians have a fundamental responsibility to treat narcotic addiction because it is recognized as a medical syndrome based on an underlying emotional disorder. This syndrome tends to perpetuate itself and aggravate further the underlying disorder. Physical dependence without underlying emotional disorder is easily terminated and does not constitute an addiction problem. This is usually the situation if physical dependence develops in persons receiving narcotics for the relief of intractable pain.

Epidemiology

10. The opiate addiction problem can be described in terms of the interplay of three epidemiological factors:

I. The Agent

Heroin is the drug of choice of most addicts in the United States and accounts for the bulk of the problem.

II. The Host

At the present time young adult males of certain minority groups constitute the great preponderance of the cases. Many other groups of addicts can be distinguished.

III. The Environment

Drug addiction is at present chiefly a problem of certain large cities, particularly in their low socio-economic areas. It may, however, involve any part of the country or any socio-economic class.

Psychiatry

11. Disturbances of personality are usually easy to demonstrate in persons who have become addicted and are thought to precede and predispose to the occurrence of the disorder rather than being caused by the addiction. Expression of the personality disorder is aggravated by drugs but full-blown psychoses are rarely associated with the opiates except for toxic psychoses caused by intoxication with or withdrawal from non-opiate drugs.

12. Addicts as a group are lacking in frustration tolerance, are dependent and adept at manipulating those about them in relation to their addiction. They are very often amoral, hedonistic, unreliable, and difficult as patients, yet it is wrong to generalize too freely since much depends on the structure of individual psychopathology, the social and cultural background and the patient's total physiological and psychological resources. An adequate evaluation is necessary in order to prepare a course of action with respect to any particular case, and one cannot rely on general statements which purport to relate uniformly to all addicts, since there are many variations and exceptions.

Clinical Course and Nature of History of Addiction

13. Addiction to heroin and to other opiates, once established, has the characteristics of a chronic relapsing disease. Withdrawal is the least complex part of treatment; indeed, it is periodically accomplished by certain addicts extramurally without medical assistance. Repeated relapse occurs frequently; success or failure should not be measured solely by the single criterion of relapse. There is good reason to believe that the total course of opiate addiction is influenced

by adequate treatment and, in any event, treatment of addicted persons remains a medical responsibility. Regardless of prognosis, the physician must use available knowledge in attempting to eliminate the syndrome of addiction and to cure the underlying personality disorder. *Continued administration of drugs for the maintenance of addiction is not a bona fide attempt at cure, nor is it ethical treatment except in the few unusual circumstances discussed later.*

16. In such cases the physician should obtain consultation and is required to maintain adequate records of the drugs administered and the indications for such administration. He must also maintain adequate safeguards against diversion of drugs into illicit channels.

Administration of Narcotics to Aged and Debilitated Addicted Persons

17. Occasional cases of addiction in aged and infirm or severely ill persons are found in which withdrawal of narcotics may be dangerous to life (*2*). As long as danger to life from withdrawal is present it is proper and necessary to maintain a supportive level of narcotic medication, provided the opinion is confirmed by adequate consultation, proper records are kept, adequate safeguards against diversion of narcotics are maintained and the patient is closely supervised.

Administration of Narcotics to Relieve Acute Withdrawal Symptoms

18. There has never been any legal or medical question of the right and duty of a physician to administer limited quantities of narcotics for a few days in a hospital or other secure setting which is reasonably certain to be drug free in order to relieve acute withdrawal symptoms. The drug of choice is methadon and various schedules of application are available. "Cold turkey" as routing "treatment" of addicted persons, including those in detention facilities, is contraindicated. In New York this has been specifically forbidden and the right of the addict to a humane withdrawal is established by a state law (Metcalf-Volker Act, 1962).

Diagnosis

14. Diagnosis is based primarily on history, physical examination, and observation. Diagnosis of the fact of addiction is usually not difficult but assessment of the degree and the pattern of addiction are far more complex. Addicts regularly overestimate the amount of drugs they have been taking, especially now that most illicit drugs are diluted. It is particularly important to be aware of combinations with barbiturates because of convulsions and delirium which occur when these latter are suddenly withdrawn. Laboratory tests are available for opiates in the urine but they are not now in general use. The administration of opiate antagonists such as nalorphine to precipitate the withdrawal syndrome for the detection of drug use requires

special skill and experience. Chief reliance should be placed on clinical techniques of diagnosis and evaluation. Not all physicians will have equal skill and experience in this field and, where indicated, suitable consultations should be obtained.

Administration of Narcotics to Persons With Intractable Pain

15. It is generally recognized that it is proper ethical practice to administer narcotics over a prolonged period in the treatment of patients with chronic incurable and painful conditions (*2*), where all reasonable alternate procedures have failed. This is especially true in terminal disorders but, in certain unusual instances, may apply also to other non-fatal diseases with intractable pain where no relief or cure is possible or where none has been found after reasonable efforts.

Requirements for Withdrawal

A. Institutional

19. Withdrawal is most easily carried out in a drug-free environment in specialized wards or installations for narcotic addicts and such installations have been increasing in number within recent years as, for example, in New York State and in California.

20. However, under the following conditions, withdrawal may be carried out in other settings:

(1) Few cases are involved;
(2) The patient is well evaluated;
(3) Good control is maintained; and
(4) The physician has special skill and experience in this work.

The following settings may be acceptable:

(1) Psychiatric wards of general hospitals.
(2) A properly selected ward (usually the sick bay) of a public or private mental hospital without specialized units.
(3) Certain general hospital wards.

B. Ambulatory

21. Withdrawal on an ambulatory basis is generally medically unsound and not recommended on the basis of present knowledge. Only under exceptional circumstances* is it proper to attempt withdrawal on an ambulatory basis and then *only* by a physician with special skill and experience in the management of addicted patients. In such cases there should always be consultation with a psychiatrist, if one is available, or with another physician experienced in this field, or with another physician who will substantiate the fact that ambulatory withdrawal is, in fact, indicated.

22. Methadon is usually the drug of choice and the patient should in no case be given medication at any visit that will provide for his

*Included among the factors to be evaluated and the circumstances to be considered, are elements such as extent of delinquency record, degree of motivation and nature of introduction to drug use.

needs for more than one day nor should he receive more of the drug than is necessary to reduce abstinence distress to a mild level. Patients should be seen daily by the physician himself and only oral medication, preferably liquid, should be dispensed. Treatment should be promptly terminated if the patient is found to be securing additional drugs elsewhere or if he fails to maintain a pre-arranged schedule for withdrawal. Withdrawal should be completed within a three-week period. If there is complicating physical illness which makes this a danger to life, and withdrawal is to be undertaken, hospitalization is always required.

23. It is recommended that the patient should agree in writing to follow the advice of the physician and not to obtain drugs from other sources.

24. Adequate records are required (*2*, *11*) on all cases and should include physical examination, history, a record of the consultation as well as copies of agreements with the patient and the records of the visits and actual medication administered to the patient.

25. In cases of pregnancy, withdrawal should be carried out prior to delivery; otherwise, the child must also be carried through a withdrawal schedule.

Interim Treatment of Addict on a Waiting List for Admission to a Narcotic Facility

26. Where the diagnosis of addiction has been established and when a patient is awaiting admission to a treatment facility and the fact of his acceptance and the date of admission have been confirmed by the attending physician, oral maintenance with methadon, preferably in liquid form, may be given on daily visits by the physician for not more than ten days to two weeks. Needed dosage will be established by observation of response to medication. No more than one day's medication should be dispensed to the addict at one time.

Ambulatory Withdrawal Clinics

27. The 1962 joint AMA–NRC statement (9) reads:

> ". . . Ambulatory clinic plans for the withdrawal of narcotics from addicts are . . . generally inadequate and medically unsound."

This position is taken "on the basis of present knowledge" and is intended to cover current clinical practice; it is not intended to obstruct bona fide research (see under Research).

Ambulatory Maintenance and Continued Administration

28. The joint statement covers this much debated issue as follows:

> "*The maintenance of stable dosage levels is generally inadequate and medically unsound* and ambulatory clinic plans for the with-

CONTINUED

1 OF 2

drawal of narcotics from addicts are likewise generally inadequate and medically unsound. (Emphasis supplied.)

"As a result of these conclusions the American Medical Association and the National Research Council oppose on the basis of present knowledge such ambulatory treatment plans."

29. In fact, as pointed out earlier, ambulatory maintenance can be considered ethical medical practice only if consultation has been had and it is agreed by the physicians concerned that (a) withdrawal would be hazardous to life, or (b) continued drug administration is necessary for a chronic or terminal painful condition other than the drug addiction itself and for which no other mode of treatment is feasible.

Definitive Treatment

30. After withdrawal a therapeutic program of up to six months or even a year is often indicated and this is best carried out in specialized facilities. However, physicians with specialized experience in this field who have established a good working relationship with the patient can and do carry out treatment in other institutional settings and provide follow-up services with long-term aftercare in the community.

31. Information as to inpatient facilities is available on a local basis from the state or local agency having to do with health matters, or from local voluntary and professional groups such as local medical societies or mental health associations.

32. Physicians will often wish to refer patients to such facilities for definitive care. Certification to civil facilities is possible in a number of states and its broader application is recommended. It may supply the element of compulsion toward maintenance of treatment which most addicts require. Information or certification is also available from the sources named in paragraph 30.

Aftercare and Rehabilitation

33. After a patient has had even the best available treatment in any special closed facility his subsequent course will depend to a significant degree on the type and adequacy of aftercare, the social, economic and psychiatric rehabilitation program which can be provided and the environment to which the patient returns. Physicians should play an important role in the mobilization of social resources for aftercare and in providing supervision and follow-up treatment.

34. Relapse requires retreatment and should not be taken as indication of failure, but should be accepted as in any other relapsing disorder. There is suggestive evidence that with the passage of time, patients tend to become more responsive to treatment and an increasing number of cases "mature out" of addiction.

Prevention

35. Physicians should be fully informed in order that they:
   (1) May play their role in the program of public education on the dangers of narcotic drugs.
   (2) Can discharge the basic responsibility for controlling their administration of narcotics in such a way as to avoid diversion to illicit use or the creation of addiction.

Legal and Regulatory Aspects

36. A physician must comply with local, state and federal narcotic laws and regulations. A copy of the federal regulations (*2, 11*) can be obtained from the Bureau of Narcotics at the Department of the Treasury, Washington, D.C., or from the nearest District Supervisor for the Federal Bureau of Narcotics. Information as to local and state regulations can be obtained from the physician's county or state medical society.

37. Any future recodification of laws or of regulations should be couched in language as simple and direct as possible with a balanced emphasis on the positive as well as negative aspects of treatment of addicts.

38. In order to promote a better coordination between law enforcement and medical treatment, responsible medical bodies should be developed in each state to collaborate with the Federal Bureau of Narcotics or appropriate state agencies in the investigation of physicians under question concerning their prescribing or dispensing of narcotics. The medical profession recognizes the need for this sort of procedure to be established and stands ready to cooperate with the Federal Bureau of Narcotics and appropriate state agencies in such an undertaking.

39. In addition, there appears to be a need for a medical body on a national level to maintain a current "code" of ethical medical practice with relation to narcotics and narcotic addiction and to act in an advisory capacity to the Commissioner of Narcotics. The American Medical Association and the National Academy of Sciences—National Research Council stand ready to cooperate with the Commissioner in this regard.

40. It is recommended that the national body should meet not less than every two years and publish any new material within three months.

Research

41. It is apparent that research on the problems of addiction to narcotics is absolutely necessary. The joint statement of the American Medical Association and the National Research Council Committees (*9*) was very explicit in emphasizing that the judgment of these organizations about ambulatory withdrawal and ambulatory maintenance was based on "present knowledge" and it characterized these methods as generally inadequate and unsound but there was no intent or desire to prevent any future research efforts (*12*).

42. There is urgent need for further investigations of many types, both at clinical and basic science levels, and future findings may make it necessary to revise further our current concepts of what constitutes ethical medical practice in relation to narcotics and narcotic addicts.

43. Many of the restrictions on the use of narcotics in general medical practice may properly be modified for the purpose of bona fide research activities since research creates special requirements. Such activities, however, must be carried out within the limits of ethical medical practice as applied to research.

SUMMARY

1. Laws and regulations controlling narcotic drugs are not intended to interfere with their administration in legitimate medical practice. Such administration is legally and medically sound.

2. It is a responsibility of the medical community to provide on a current basis a "code" defining legitimate medical practice. The present report represents a review of such current opinion as will tend to meet this need.

3. The WHO definition of addiction is adopted for this document but consideration is limited to the opiates, and the natural and synthetic drugs of this class.

4. Heroin is the principal drug of addiction in the United States and moves entirely through illicit channels. Other opiates have a proper and necessary place in medical practice but special limitations and precautions are required because of their addiction producing capacities.

5. It is the duty of the physician to bear these dangers in mind in his administration of narcotics.

6. It is his duty to:
   (*a*) Maintain adequate records.
   (*b*) Maintain adequate precautions to prevent diversion of drugs to illicit channels or creation of addiction.
   (*c*) Know and obey relevant local state and federal laws and regulations on prescribing and dispensing narcotics and on narcotic addiction.

7. Narcotics may properly be given over prolonged periods of time to patients with chronic painful diseases other than drug addiction itself if a reasonable use of alternative procedures fails to give relief in the following:
   (*a*) Terminal states.

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(*b*) In chronic painful diseases for which no cure or other relief is known.

8. In such cases the physician should secure medical consultation.

9. The treatment of persons already addicted is a medical responsibility because addiction is recognized to be a medical syndrome which is based on an underlying emotional disorder. This syndrome tends to perpetuate itself and to further aggravate the underlying disorder.

10. Within the field of medicine, addiction is a problem in psychiatry and in psychopharmacology.

11. Under adequate precautions (in or out of an institution) and after proper consultation, addicted persons may be supplied with maintenance drugs if withdrawal represents a hazard to life. Oral medication with methadon will usually suffice.

12. All addicted persons including those under confinement should be given a humane medical withdrawal under medical supervision. There is no excuse for the so-called "cold turkey" treatment.

13. Successful narcotic withdrawal involves four interacting factors:

(*a*) The degree of control afforded by the environment.

(*b*) The skill and experience of the physician.

(*c*) The patient and his attitude.

(*d*) The type of drug and degree of addiction.

14. Optimally, withdrawal is carried out in a closed specialized narcotic treatment unit since it requires a drug-free environment.

15. Patients can also be withdrawn under suitable conditions in psychiatric wards of general hospitals or in selected wards of public or private mental hospitals if the drug-free situation can be attained. When cases number more than a few, consideration must be given to the development of special narcotic treatment units.

16. If all factors are favorable, withdrawal may be possible in a general hospital or a private institution.

17. Withdrawal on an ambulatory basis is generally medically unsound and not recommended on the basis of present knowledge. A possible exception has been described.

18. Oral methadon may be supplied on a daily dose basis to protect an addict from withdrawal symptoms for a period up to ten days or two weeks if the attending physician has confirmed that the patient has been accepted for and is awaiting admission to a facility for the treatment of narcotic addiction.

19. Long-term follow-up involves the mobilization of community resources for vocational and social rehabilitation. The physician's supervision and supportive role to this end is important.

20. Addiction has the characteristics of a chronic relapsing psychiatric disorder and must be viewed in this perspective in evaluating the results of treatment.

21. To promote a better coordination between law enforcement and medical treatment, responsible medical bodies should be developed in each state to collaborate in the investigation of physicians under question concerning alleged irregularities of prescribing or dispensing narcotics. The medical profession recognizes this need and stands ready to cooperate with the Commissioner of the Bureau of Narcotics and appropriate state agencies in such an undertaking.

22. A need exists for the development of a national body to keep current the standards of ethical medical practice with relation to narcotics and narcotic addicts and to act in an advisory capacity to the Commissioner. The American Medical Association and the National Academy of Sciences-National Research Council stand ready to cooperate with the Bureau of Narcotics in this regard.

23. Many of the restrictions on the use of narcotics in general medical practice may properly be modified for the purpose of bona fide research activities since research creates special requirements. Such activities, however, must be carried out within the limits of ethical medical practice as applied to research.

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(*9*) Joint Statement of AMA and NRC Committees. Released at press conference, May 14, 1962. New York Medicine, 561, August 20, 1962.

(*10*) Expert Committee on Addiction-Producing Drugs, World Health Organization Technical Report, Series No. 116, Geneva, 1957.

(*11*) Regulations No. 5. Regulatory Taxes on Narcotic Drugs, Opium, Coca Leaves, Isonipecaine or Opiates. Part 151 of Title 26 (1954), Code of Federal Regulations. U.S. Treasury Department, Joint Regulations of the Bureau of Narcotics and Internal Revenue Service. IRS Publication No. 428 (6–59).

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JOINT STATEMENT ON NARCOTIC ADDICTION

by

AMERICAN MEDICAL ASSOCIATION

and

NATIONAL RESEARCH COUNCIL

The American Medical Association and the National Research Council for many years have been concerned about and have studied the narcotic drug addiction problem. To assist in carrying out its studies, the American Medical Association collaborated with the American Bar Association in establishing a Joint Committee which made an Interim Report to the two organizations in 1958, and a Final Report in 1959.

It is concluded that there is widespread public and professional misunderstanding about this subject, specifically (1) that the Federal Bureau of Narcotics believes drug addiction to be a crime; a belief that is contrary to the Federal law and its application by the Bureau, and (2) that the American Medical Association proposes the establishment of community ambulatory clinics for the withdrawal of narcotics from addicts or for the continuing maintenance of addicts on narcotics; a belief that is contrary to the official position of the American Medical Association.

Historically, society has found it necessary to employ legal controls to prevent the spread of certain types of illness that constitute a hazard to the public health. Drug addiction is such a hazard.

The successful and humane withdrawal of individuals addicted to narcotics in the United States necessitates constant control, under conditions affording a drug-free environment, and always requires close medical supervision.

The successful treatment of narcotic addicts in the United States requires extensive post-withdrawal rehabilitation and other therapeutic services.

The maintenance of stable dosage levels in individuals addicted to narcotics is generally inadequate and medically unsound and ambulatory clinic plans for the withdrawal of narcotics from addicts are likewise generally inadequate and medically unsound.

As a result of these conclusions the American Medical Association and the National Research Council oppose on the basis of present knowledge such ambulatory treatment plans.

These two organizations support (1) after complete withdrawal, followup treatment for addicts, including that available at rehabilitation centers, (2) measures designed to permit the compulsory civil commitment of drug addicts for treatment in a drug-free environment, (3) the advancement of methods and measures towards rehabilitation of the addict under continuing civil commitment, (4) the development of research designed to gain new knowledge about the prevention of drug addiction and the treatment of addicted persons, and (5) the dissemination of factual information on narcotic addiction.

AMA RESTATES POSITION ON AMBULATORY CLINICS FOR ADDICTS

Confusion on the part of the public and some medical organizations has resulted in a restatement by the AMA of its position on ambulatory clinics for treatment of drug addicts.

Briefly, its position is this: It opposes "on the basis of current knowledge" general, non-experimental ambulatory treatment services, but endorses "an experimental facility for the out-patient treatment of drug addicts, to explore the possibility of dealing with at least some types of addicted persons in the community."

In a letter to the Saturday Evening Post, which in its Sept. 8 issue stated that the AMA had "repudiated" its position on ambulatory clinics, Dr. Dale C. Cameron, chairman of the AMA Committee on Narcotic Addiction, clarified the AMA stand. John Kobler, author of the Post article, "The Narcotics Dilemma: Crime or Disease?" had misinterpreted the intent of two reports adopted by the AMA House of Delegates, he said. The reports were the joint statement of the AMA and the American Bar Association, endorsed in 1959, and the 1962 statement prepared by the AMA and the National Research Council.

Both documents specifically called for stepped-up research in the prevention and treatment of narcotic addiction, Cameron said. He noted that the AMA–ABA statement endorsed an experimental clinic for outpatient treatment. At the same time, the report warned that "no acceptable evidence whatsoever points to the indiscriminate distribution of narcotic drugs as a method of handling the problem of addiction."

To date, the AMA official said, no properly controlled "experimental facility" has been established, though the development of such project was reendorsed by the AMA–NRC statement. "This is why the AMA–NRC, speaking of general, non-experimental treatment services stated that 'on the basis of current knowledge' they oppose ambulatory clinics. Certainly the report does not preclude future recommendations based on any new knowledge gained through research," Cameron said.

"WHO" DEFINITION OF DRUG ADDICTION

Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

(1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
(2) a tendency to increase the dose;
(3) a psychic (psychological) and generally a physical dependence on the effects of the drug;
(4) an effect detrimental to the individual and to society.

Drug addiction is distinguished from drug habituation which is defined as follows:

Drug habituation (habit) is a condition resulting from the repeated administration of a drug. Its characteristics include:

(1) a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being that it engenders;
(2) little or no tendency to increase the dose;
(3) some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome;
(4) a detrimental effect, if any, primarily to the individual.

Expert Committee on Addiction-Producing Drugs. Seventh Report. World Health Organization Technical Report, Series No. 116, 1957.

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APPENDIX II

AMERICAN SOCIAL HEALTH ASSOCIATION

FACILITIES PROVIDING SERVICES FOR NARCOTIC USERS

November 1963

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FACILITIES PROVIDING SERVICES FOR NARCOTIC USERS

November 1963

Hospitals and Clinics

Governmental	*Non-Governmental*
Alabama	
State mental hospitals (accept addicts committed as mental patients).	Hill Crest Sanitarium (P)* (Birmingham) (has program and facilities).
California	
Atascadero State Hospital (Atascadero) (routine psychiatric services; very active patient government).	
Langley-Porter Neuropsychiatric Institute (San Francisco) (physician addicts treated).	
Metropolitan State Hospital (Norwalk) (Psychiatric services).	
Patton State Hospital (Patton) (short-term treatment, about 90 days).	
San Francisco General Hospital, Psychiatric Unit (San Francisco) (treats addicts).	
Stockton State Hospital (Stockton) (accepts court-committed addicts; 1 month to 2 years).	
Other state mental hospitals accept addicts at discretion of director of hospital.	
Colorado	
Colorado Psychopathic Hospital (Denver) (treats acute reactions associated with withdrawal; refers to another facility for long-term treatment).	Emory John Brady Hospital (P) (Colorado Springs) (occasionally admits addicts).
Colorado State Hospital (Pueblo) (admits addicts, but no formal program).	Mount Airy Hospital (V)* (Denver) (psychotherapy; chemotherapy; occupational therapy; physical therapy; other supportive auxiliary therapies).
Denver General Hospital (Denver) (no special services; only emergency treatment).	

*(P) Proprietary. (V) poluntary.

Governmental	*Non-Governmental*
Connecticut	
Fairfield State Hospital (Newtown) (psychiatric observation; short-term hospitalization).	
Franklin S. DuBois Psychiatric Day Treatment Center (Stamford) (to begin operation in early 1964; will treat, but no special facilities).	
Delaware	
Delaware State Hospital (Farnhurst) (treats some addicts).	
District of Columbia	
D.C. General Hospital, Psychiatric Hospital (has treatment and rehabilitation program).	
Florida	
Florida State Hospital (Chattahoochee) (treats court-committed addicts who have history of other psychiatric illness, not admitted on basis of narcotic addiction alone).	Holiday Hospital & Sanitarium (V) (Orlando) (treats some users referred by private physicians).
Lowell State Prison Hospital (Lowell) (withdrawal and 6 months abstinence).	
Georgia	
Midgeville State Hospital (Midgeville) (has treatment and rehabilitation program).	Brawner Hospital (P) (Smyrna) (treats addicts).
Hawaii	
Hawaii State Hospital (Kaneohe) (limited treatment facility for detoxification).	
Illinois	
Department of Public Safety, Division of Narcotic Control (Springfield) (Narcotic Ward of Bridewell Hospital provides withdrawal treatment; periodic testing).	Keeley Institute (P) (Dwight) (medical, physical and psychiatric therapy; group and individual counseling).
Jacksonville State Hospital (Jacksonville) (admits court-committed addicts).	
Iowa	
Broadlawns Polk County Hospital (Des Moines) (admits addicts; has psychiatric facilities).	Iowa Methodist Hospital (V) (Des Moines) (complete psychiatric facility).
	Hillcrest Hospital (V) (Des Moines) (admits addicts; psychiatric only).

Governmental	*Non-Governmental*
Kansas	
Ossawatomie State Hospital (Ossawatomie) (accepts addicts for limited psychotherapy and drugs—if admitted for other associated emotional illness).	
Topeka State Hospital (Topeka) (diagnostic; all conventional therapies).	
Kentucky	
U.S. Public Health Service Hospital (Lexington) (exclusively for addicts).	
Louisiana	
East Louisiana State Hospital (Jackson) (limited treatment; referral made to federal hospitals for prolonged treatment).	De Paul Hospital (V) (New Orleans) (treats addicts).
Maryland	
Crownsville State Hospital (Crownsville) (not yet operating; program planned).	
Clifton T. Perkins Hospital (Jessups) (diagnostic; short-term treatment, then referral to Spring Grove State Hospital. Program to begin December 1963).	
Spring Grove State Hospital, Narcotic Unit (Catonsville) (treatment and rehabilitation program; follow-up in out-patient clinic).	
Massachusetts	
	Baldpate Hospital (P) (Georgetown) (accepts addicts).
	Washingtonian Hospital (V) (Boston) (specializes in addictive diseases).
Michigan	
Receiving Hospital (Detroit) (plans for Narcotics Clinic with treatment and rehabilitation program).	
Kent Oaks Hospital (Grand Rapids) (treats addicts, but no special program).	

Governmental *Non-Governmental*

Minnesota

Fergus Falls State Hospital (Fergus Falls) (treats addicts).
Minneapolis General Hospital (Minneapolis) (treats addicts).
Moose Lake State Hospital (Moose Lake) (detoxification, then absorption into general psychiatric program).
St. Peter State Hospital (St. Peter) (treats only as incidental to other mental illness).
Willmar State Hospital (Willmar) (treats addicts).

Mississippi

Leonard Wright Sanitorium (P) (Byhalia) (withdrawal treatment).

Missouri

Ralph Clinic (P) (Kansas City) (specializes in addictive diseases).

Nebraska

Hastings State Hospital (Ingleside) (treats addicts).
Nebraska Psychiatric Institute (Omaha) (accepts addicts; admissions rare).
Norfolk State Hospital (Norfolk) (treats addicts, but no special program).

New Hampshire

New Hampshire State Hospital (Concord) (admits addicts; psychiatric therapy).

New Jersey

Bergen Pines County Hospital, Division of Psychiatry (Paramus) (short-term inpatient treatment; detoxification; psychotherapy; vocational rehabilitation; outpatient psychiatric clinic).
Newark City Hospital (Newark) (medical treatment associated with acute withdrawal symptoms).
New Jersey State hospitals (take only emergency situations).

Governmental *Non-Governmental*

New Mexico

New Mexico State Hospital (Las Vegas) (admits court-committed addicts).

New York

Brooklyn State Hospital (Brooklyn) (treats addicts admitted for other than mental illness).
Buffalo State Hospital, Narcotic Addiction Unit (Buffalo) (treatment and rehabilitation).
Central Islip State Hospital (Central Islip) (has treatment program).
Manhattan State Hospital (New York City, Ward's Island) (patients selected for research purposes).
Metropolitan Hospital (New York City) (treatment program).
E. J. Meyer Memorial Hospital (Buffalo) (county) (addicts accepted, but no special facilities).
Middletown State Hospital (Middletown) (program for women addicts).
Monroe County Home Infirmary (Rochester) (detoxification).
New York State Psychiatric Institute (New York City) (treats addicts who have been admitted for associated mental illness).
Pilgrim State Hospital (West Brentwood) (detoxification and rehabilitation).
Rochester Municipal Hospital, Psychiatric Clinic (Rochester) (detoxification).
Sea View Hospital & Home (Staten Island) (teenage addicts and adult female addicts treated).
Utica State Hospital (Utica) (voluntary and court-admitted addicts treated).

State-operated clinics under the Department of Mental Hygiene

After-care Clinic, Manhattan State Hospital (New York City).
After-care Clinic, 39 East 17th Street, New York City (both clinics for patients released from Department of Mental Hygiene hospitals).

Albany Medical Center Hospital, Psychiatric Clinic (V) (Albany) (psychiatric services for outpatient adults; hospitalization for withdrawal).
Strong Memorial Hospital (V) (Rochester) (detoxification).

New York City

Gracie Square Hospital (P) (treats addicts).
Manhattan General Hospital (P) (short-term treatment; under contract with New York City).
Payne Whitney Psychiatric Clinic (V) (treats addicts).
Rockefeller Institute Hospital (V) (program to begin January 1964; research-oriented; treatment provided for selected patients).
St. Luke's Hospital, Psychiatric Service (V) (in-patient treatment).
St. Vincent's Hospital, Psychiatric Clinic (V) (out-patient treatment).
Charles B. Towns Hospital (P) (specializes in addictive diseases).

Governmental *Non-Governmental*

New York—Continued

New York City hospitals with mental hygiene clinics to which addicts may be referred
- Bellevue Hospital Center
- Bronx Municipal Hospital Center
- Coney Island Hospital
- Cumberland Hospital
- Elmhurst City Hospital
- Harlem Hospital
- Kings County Hospital
- Metropolitan Hospital
- Morrisania City Hospital
- Queens General Hospital Center

North Carolina

Dorothea Dix Hospital (Raleigh) (state mental hospital; treats voluntary or court-committed addicts; group therapy; withdrawal treatment; education).

Appalachian Hall (P) (Asheville) (psychiatric; for drug addicts with history of alcoholism).

Highland Hospital (V) (Asheville) (psychiatric; for drug addicts with history of alcoholism).

Keeley Institute (P) (Greensboro) (treats withdrawal symptoms; counseling; psychiatric evaluation).

Ohio

Longview State Hospital (Cincinnati) (admits addicts, but no special program).

Rollman Psychiatric Institute (Cincinnati) (treats voluntary or court-committed patients whose addiction is conicidental to other psychiatric illness; no special program; a state institution).

Woodside Receiving Hospital (Youngstown) (admits court-committed addicts).

The Central Clinic (Cincinnati) (diagnostic evaluation; out-patient psychotherapy for non-active addicts) (Central Clinic also supported by Ohio State Division of Mental Hygiene).

Oregon

F. H. Demmasck State Hospital (Wilsonville) (withdrawal symptoms treated and enforced abstinence for approximately one month).

Eastern Oregon State Hospital (Pendleton) (treats addicts).

Oregon State Hospital (Salem) (routine psychiatric care).

Bureau of Health (Portland) (medical therapy for withdrawal; complete physical examination; nalline testing).

Governmental *Non-Governmental*

Pennsylvania

Alcoholic Studies & Rehabilitation Section, State Department of Health (Harrisburg) (clinical services).

Pennsylvania Institute for Alcoholism and Narcotic Addiction (Philadelphia) (out-patient medical and psychiatric treatment).

Rhode Island

Rhode Island Medical Center, Institute of Mental Health (Howard) (withdrawal treatment; psychotherapy; occupational therapy).

South Dakota

Yankton State Hospital (Yankton) (medical and psychiatric services for voluntary or court-committed addicts, but no special program).

Texas

Austin State Hospital (Austin) (treats addicts).

U.S. Public Health Service Hospital (Fort Worth) (comprehensive medical, surgical, psychiatric and rehabilitative services for voluntary and court-committed users).

Utah

Utah State Hospital (Provo) (admits addicts; psychiatric services).

Salt Lake County General Hospital (Salt Lake City) (withdrawal treatment; no special program).

Vermont

Vermont State Hospital (Waterbury) (treats addicts, but no structured program).

Washington

Seattle King County Department of Public Health (Seattle) (sedation during acute withdrawal).

Tacoma-Pierce County Health Department, Mental Health Division (Tacoma) (medical and psychiatric evaluation; short-term treatment; psychotherapy and counseling).

Governmental	*Non-Governmental*
West Virginia	
West Virginia State Mental Hospital c/o Kanawha County Mental Hygiene Commission (Charleston) (narcotic user treated under "inebriate" treatment program).	
Wisconsin	
Mendota State Hospital (Madison) (has treatment and rehabilitation program for court-committed users).	
Milwaukee County General Hospital (Milwaukee) (bill passed providing for treatment and rehabilitation of addicts).	
Winnebago State Hospital (Winnebago) (treats addicts, but no specific program).	

REHABILITATION CENTERS AND TREATMENT and/or REHABILITATION PROGRAMS (other than hospitals)

Governmental	*Non-Governmental*
California	
California Institute for Men (Chino).	Educational Alliance (Los Angeles).
California Institute for Women (Frontera).	Teen Challenge Center (Los Angeles).
California Rehabilitation Center (Norco-Corona).	
California Institute for Men (San Quentin).	
California Rehabilitation Center (Tehachapi).	
Santa Rita Rehabilitation Clinic (Santa Rita).	
Connecticut	
	Narcotic Addiction Service Center of Southwestern Fairfield County (Stamford).
Georgia	
	The Bradley Center (Columbia) (Outpatient psychotherapy for non-active, motivated patients).
Hawaii	
State Health Department (addict rehabilitation).	
Illinois	
	Teen Challenge Center (Chicago).

Governmental	*Non-Governmental*
Kentucky	
Kentucky Department of Health, Division of Investigation and Narcotic Control (rehabilitation program for physicians and other medical people).	
Massachusetts	
Massachusetts Correctional Institution (Bridgewater) (care and treatment of addicts).	
New York	
State Department of Education, Division of Vocational Rehabilitation (only if addiction is associated with a primary physical or emotional handicap).	*New York City:*
State Department of Mental Hygiene.	Catholic Charities, Archdiocese of New York.
New York City:	Civic Center Clinic (BARO).
Astoria Rehabilitation Center.	Community Guidance Service.
Central Harlem Rehabilitation Center.	Damascus Christian Church.
Washington Heights Rehabilitation Center.	East Harlem Protestant Parish Narcotics Committee.
West Side Rehabilitation Center.	Greenwich House Counseling Center Haven.
Community Mental Health Board.	Jewish Family Service Social Rehabilitation Department.
Department of Health.	Lower Eastside Information and Service Center for Narcotic Addiction.
Department of Hospitals.	Quaker Committee on Social Rehabilitation.
	Salvation Army, Women's Correctional Service.
	Teen Challenge Center.
	Village Aid and Service Center.
	Village Haven.
Oregon	
Department of Public Safety, Bureau of Health (Portland) (some psychiatric treatment while in hospital).	
Pennsylvania	
State Department of Health, Alcoholic Studies and Rehabilitation Section.	Teen Challenge Training Center (Rehrersburg).
Utah	
Department of Health, Bureau of Education (Salt Lake City) (treatment and education).	
Virginia	
State Alcoholic Studies and Rehabilitation.	

COORDINATION, REFERRAL AND AID IN COMMITMENT and/or TREATMENT

Governmental	*Non-Governmental*
Alabama	
Birmingham Police Department.	
Arizona	
Arizona Health Department.	
Arkansas	
Arkansas Board of Health.	
California	
Pasadena Police Department. State Department of Mental Hygiene (Sacramento).	California Association for the Prevention of Addiction to Narcotics (Los Angeles). Educational Alliance (Los Angeles). Integrators Foundation (Los Angeles).
Connecticut	
Narcotics Advisory Council (Hartford).	Community Council of Greater New Haven (New Haven). Narcotic Addiction Service Center of Southwestern Fairfield County (Stamford).
Florida	
State Board of Health, Bureau of Narcotics.	
Georgia	
Health Department (District 37) (Savannah).	
Hawaii	
State Department of Health.	
Michigan	
Detroit Department of Health. Mayor's Committee for the Rehabilitation of Narcotic Addicts (Detroit). Saginaw Police Department.	
Minnesota	
State Department of Public Welfare.	
Missouri	
	Metropolitan Youth Commission of St. Louis and St. Louis County.
New Jersey	
Narcotic Control Commission (Trenton).	New Jersey Welfare Council (Newark). Mount Carmel Guild Narcotic Center (Newark).

Governmental	*Non-Governmental*
New York	
State Department of Mental Hygiene. State Employment Service. Cumberland Hospital (Brooklyn). New York City Department of Health, Office of the Narcotics Coordinator. Washington Heights Rehabilitation Center (New York).	*New York City.* Brooklyn Bureau of Social Service and Children's Aid Society. Community Guidance Service. Community Service Society. Foundation for Day Hospitals and Pilot Programs. Harlem Neighborhoods Association. Isaac T. Hopper Home (referral only). Legion of Mary. Lower Eastside Information and Service Center for Narcotic Addiction. Mobilization for Youth. New York Council on Narcotic Addiction (includes a number of neighborhood-based programs). National Family Council on Drug Addiction. New York Friends Center. New York Society, Ethical Culture. 30th Precinct Youth Council. Trinity Parish Counseling Service. Vocational Foundation. Teen-age Evangelism. Village Haven.
Pennsylvania	
Pennsylvania Department of health. Institute for Alcoholism and Narcotic Addiction (Philadelphia).	
Rhode Island	
Rhode Island Department of Health.	
Texas	
	Vocational Guidance Service (Houston).
Utah	
Utah Department of Health.	
West Virginia	
Charleston Guidance Clinic (Charleston).	

INFORMATION AND EDUCATION

Governmental | *Non-Governmental*

Arkansas

Board of Health (Little Rock).

California

San Diego County Probation Department.
Pasadena Police Department.

Los Angeles:
Educational Alliance.
Narcotic Education Foundation.
Welfare Planning Council, Los Angeles Region.

Connecticut

Connecticut Department of Education.

Foundation for Alcohol Education (Bridgeport).

District of Columbia

Narcotics Education, Inc.

Hawaii

State Department of Education.
State Department of Health.

Illinois

State Department of Public Safety, Division of Narcotic Control.

National Women's Christian Temperance Union, Narcotic Education Bureau (Evanston).

Indiana

Social Health Association of Indianapolis and Marian County (Indianapolis).

Michigan

Detroit Department of Health.

Association for the Advancement of Instruction about Alcohol and Narcotics (Lansing) (being reactivated).

Missouri

Kansas City Social Health Society.

New Jersey

Bellevue Board of Education (Bellevue).

Mount Carmel Guild Narcotic Center (Newark).
New Jersey Welfare Council (Newark).

Governmental | *Non-Governmental*

New York

New York City Department of Health, Office of the Narcotics Coordinator.
Washington Heights Rehabilitation Center (New York).

New York City:
Comeback.
Foundation for Day Hospitals and Pilot Programs.
Haven.
Lower Eastside Information and Service Center for Narcotic Addiction.
Mobilization for Youth.
New York Council on Narcotic Addiction.
National Family Council on Drug Addiction.
New York Friends Center.
New York Society, Ethical Culture.
Teen-age Evangelism.
30th Precinct Youth Council.
Trinity Parish Counseling Service.
Village Haven.

Oregon

State Board of Control, Division of Mental Health.

Pennsylvania

State Department of Health, Alcoholic Studies and Rehabilitation Section.

Texas

Texas Alcohol-Narcotics Education (San Antonio).

Utah

State Department of Health, Bureau of Health Education.
State Department of Public Instruction.

Washington

State Board of Health, Bureau of Foods and Drugs.

HALFWAY HOUSE

Governmental	*Non-Governmental*
California	
East Los Angeles Halfway House (Los Angeles).	Synanon House (Santa Monica). Synanon House (San Diego). Teen Challenge Center (Los Angeles).
Connecticut	
	Synanon House (Westport).
Florida	
	Teen Challenge Center (Miami).
Illinois	
	St. Leonard's House (Chicago). St. Mark's Episcopal Church Halfway House (Chicago). Teen Challenge Center (Chicago).
Nevada	
	Synanon House (Reno).
New York	
	New York City: Damascus Christian Church. Quaker Committee Halfway House. Salvation Army. Village Haven (to begin operations December 1963). Daytop Lodge (Tottenville, Staten Island).
Pennsylvania	
	Teen Challenge Center (Rehrersburg).
Texas	
	Vocational Guidance Service (Houston) (to sponsor halfway house opening shortly).

NARCOTICS ANONYMOUS

California

Correctional Training Facility, Soledad
Terminal Island Correctional Institution, Terminal Island

Michigan

Marquette Prison, Marquette
Jackson Prison, Jackson

Nevada

Reno State Prison (Reno)

New Jersey

Chapters in Hackensack
Newark (2 chapters)
Passaic
Jersey City (to be established)
Union City (to be established)

New York

New York City chapters:
c/o YMCA, 215 West 23d Street, New York City
c/o St. John Chrysostom's, 985 East 167th Street at Hoe Avenue, Bronx
c/o Fellowship House, 836 East 165th Street, Bronx

Washington

Camp Narcotic Group, Steilacoom
Chapter also in Walla Walla

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