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CRIMINAL LAW CASE NOTES AND COMMENTS

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THE DRUG ABUSE PROBLEMS AND SOME PROPOSALS

GUY P. SEABERG

DRUGS AND THE PATTERN OF ADDICTION

Those drugs which are the principal commodities of the illicit market, the subject of frequent abuse, and the object of both federal and state narcotics legislation may be classified in four general categories: the opiates, the barbiturates, the amphetamines, and the hallucinogens. Each has its own distinct characteristics, although many have overlapping features. Not all are narcotics;¹ and not

all are physically addictive, although they may be habit forming, a distinctly different characteristic. Each has a pronounced and distinguishable physiological effect on a user.

The opium derivatives will be discussed at some length because they are the major drugs of addiction and the principal objects of the bulk of legislation to be considered. The remaining categories will be taken up in order.

Opiates

The "opiates" are a true narcotic. They are the drugs derived from plants of the poppy family, and include morphine and codeine—the natural alkaloids derived from opium—as well as heroin, a synthetic alkaloid which in various degrees of dilution is the principal drug available in the illicit market.² Other opium derivatives exist, such as demerol, meperidine, and methadone,³ but their use is not generally widespread due to unavailability, expense, or unpleasant side-effects.

¹ Technically narcotics are those drugs which tend to induce sleep. SCHUR, *NARCOTIC ADDICTION IN BRITAIN AND AMERICA* 17 (1962).

² REPORT BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE—*The Challenge of Crime in a Free Society* 212 (1967) [Hereinafter cited as 1967 REPORT].

³ For a comprehensive table of derivatives, see generally THE PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE—*Final Report* 10 (Nov. 1963) [Hereinafter cited as 1963 *Final Report*].

Heroin is the choice of most opiate users because it has greater analgesic (pain-killing) and euphoric potential than morphine or codeine,⁴ and because it is readily available in the illicit drug market. Morphine and codeine are limited mainly to use by the medical profession for the treatment of pain or cough, although involuntary morphine addiction is the cause of subsequent heroin addiction in some instances.

Demerol is the drug frequently used by physician-addicts, primarily because of its ready availability,⁵ although it does not appeal to the general addict population. Methadone, another synthetic, has effects very like morphine, but is similarly unpopular with addicts due to its delayed effects, and the nausea, vomiting, and constipation

⁴ SCHUR, *supra* note 1 at 19.

⁵ 1963 *Final Report*, *supra* note 3 at 10.

which sometimes accompany its use. It is significant for its widespread use in the treatment of addicts under medical attention during the withdrawal period, due to its relatively mild abstinence effects.

The opiates in general have characteristics which together distinguish them from other drugs. They all have an analgesic effect; they are physiological depressants which serve to slow down the organic functions and tend to produce a state of drowsiness or lethargy; they are not psychologically depressing; to the contrary, they produce a temporary state of euphoria or well-being, without stimulation. Taken repeatedly, they are without question physically addictive,⁶ creating a physical dependence on the presence of the drug within the system, and resulting in severe pain and discomfort upon withdrawal.

Addiction to any of the opiates is a complex phenomenon not limited to physical dependence alone. It is generally defined as that state of drug usage characterized by (1) physiological dependence, (2) tolerance, and (3) habituation.⁷

Dependence

Physical dependence is basically the result of some form of organic adaptation to drugs introduced into the system. Physiological changes do occur,⁸ although their precise nature is the subject of a great deal of speculation.⁹ Whatever the internal processes may be, however, the state of physical dependence is externally manifested when the drugs are withheld for a prolonged period. The addict suffers a series of readily observable physical ailments consisting of sweating, gooseflesh, and pupil dilation in the early stages, with severe stomach and leg cramps, vomiting, diarrhea and insomnia occurring in the later stages. Body temperature and blood pressure increase, and in severe cases there is notable loss of weight. The symptoms reach their peak 48 to 72 hours after the last dose.

⁶ Vogell, Isbell and Chapman, *Present Status of Narcotic Addiction*, 138 J.A.M.A. 1019, 1020 (1948).

⁷ *Id.* at 1019.

⁸ See Isbell, *Clinical Research in Addiction in the United States*, in NARCOTIC DRUG ADDICTION PROBLEMS (1963); Seevers, *Laboratory Approach to the Problem of Addiction*, in NARCOTIC DRUG ADDICTION PROBLEMS; *supra*; see generally Ploscowe, *Some Basic Problems in Drug Addiction and Suggestions for Research*, in A.B.A.-A.M.A. JOINT COMMITTEE REPORT ON NARCOTIC DRUGS—Drug Addiction: Crime or Disease? 33-45 (1961) [Hereinafter cited as A.B.A.-A.M.A. JOINT REPORT].

⁹ Seevers, *supra* note 8 at 112-113.

age, and ordinarily subside over a five to ten day period.¹⁰

The degree of withdrawal discomfort may depend on the type of drug involved, the level of tolerance reached and the length of time of addiction. For example, the pain produced by withdrawal from methadone, used in the supervised treatment of acute addiction, is far less severe than that of heroin or morphine. Similarly, in cases where the addict is not too seriously "hooked", withdrawal is said to be considerably less distressful, though it may be psychologically traumatic. Perhaps ironically, heroin is "cut" (diluted) so often and to such a degree by peddlers in the illicit market that many cases of physical addiction are much less severe than even the user suspects, and withdrawal is relatively painless.¹¹

Where the use of drugs has been excessive and prolonged however, the physical discomfort may be quite severe and on occasion has resulted in death.¹² It is generally recognized that drugs should be withdrawn slowly to avoid the physical abstinence syndrome as much as possible,¹³ although at least one treatment center urges the "cold turkey" method (sudden and total abstinence) for psychological reasons.¹⁴

Whatever the intensity of withdrawal, its symptoms are readily recognizable by both the user and the observer, and are without question the best, if not the only, certain evidence of the state of physical dependence.¹⁵

It should be noted that all of the symptoms of physical dependence thus far referred to have been concurrent with an absence rather than presence of drugs within the addict's system. The effect of the opiates, particularly heroin, on the physiology and behavior of the addict when his demand level

¹⁰ Vogell, Isbell and Chapman, *supra* note 6 at 1021.

¹¹ See e.g., Harney, *The Requirement for Law Enforcement*, in NARCOTIC DRUG ADDICTION PROBLEMS 84 (1963). He states: "... 9 out of 10 of our users of diluted heroin mixtures in Chicago fail to show anything except the most mild symptoms on withdrawal. The extent of the distress is a 'gape and a sweat' to use the vernacular."

¹² LINDESMITH, *THE ADDICT AND THE LAW* 8 (1965); Kolb, *Factors that Have Influenced the Management and Treatment of Drug Addicts*, in NARCOTIC DRUG ABUSE PROBLEMS 23 (1963).

¹³ SCHUR, *supra* note 1 at 29.

¹⁴ Sternberg, *Synanon House—A Consideration of Its Implications for American Correction*, 54 J. CRIM. L., C. & P.S. 447 (1963).

¹⁵ Vogell, Isbell and Chapman, *supra* note 6 at 1020; Winick, *Narcotic Addiction and Its Treatment*, 22 LAW & CONTEMP. PROB. 11 (1957).

is maintained and withdrawal syndrome avoided is a separate consideration and has been the subject of some controversy. It will be reserved for discussion after a look at the two other elements of the addiction definition—"tolerance" and "habituation".

Tolerance

The factor of tolerance is generally recognized by most authorities, but its definition is elusive. It has been variously defined as "physical adjustment to the drug that results in successive doses producing smaller effects and, therefore, in a tendency to increase doses",¹⁶ and as "the process by which, as the body adapts itself to a certain drug, larger and larger doses are needed to produce the same effects".¹⁷ It has been observed that the drug initiates an organic adaptation, which becomes "enhanced with repetition of the dose of morphine so that larger doses (tolerance) are required to overcome the effects of the morphine. When the morphine is discontinued, the adaptive responses proceeded unchecked, leading to abstinence".¹⁸ In other words, the system over-reacts to the drug, so that increasing doses are needed to combat over-reaction. If this hypothesis were true, it would lead to the conclusion that the "effects" which disappear if dosage remains constant are those which prevent the occurrence of abstinence syndrome. Alternatively, "effects" may refer to the euphoric effects of the drug, although some authorities contend that where use is prolonged, euphoria disappears altogether, leaving fear of withdrawal pain the only motive for persistent use.¹⁹ Whichever theory is correct, and they are probably related, the better evidence seems to be that the demand for increasing dosage is primarily physiological in nature, with psychological complications. There is evidence that demand can be stabilized,²⁰ but the more common pattern of

addiction is one of increased use.²¹ Whether tolerance does in fact reach a maximum is a question on which authorities disagree and which further medical research must eventually answer.

Habituation

The third and probably most complicated element of opiate addiction is that known as "habituation". The term is generally used in reference to the emotional and psychological dependence on drugs,²² but it encompasses a number of complex, underlying factors, including the personality of the addict prior to drug use, as well as the sociological and environmental pressures with which he must contend. Habituation is frequently equated with the term "habit-formation", and is generally referred to in considering why drug users persist in using the drug (exclusive of physical dependence). It will be used here also in considering why certain individuals begin to use drugs at all, since it is felt that the same factors are responsible for both aspects of the problem.

The cause of habituation has been the subject of divergent, though not always inconsistent, opinions. One view is that psychological dependence on the drug is the result of a basic "personality maladjustment"²³ which causes the addict to rely on drugs as a substitute for some other form of "adoptive behavior".²⁴ Others suggest that introduction to and reliance upon drugs is primarily the result of strong environmental pressure.²⁵ A third proposal is that habit-formation and real addiction occur only after the user becomes aware that he has reached a state of physical dependence; physical need thus precipitates psychological need.²⁶

Various studies confirm the view that a high percentage of addicts are suffering from some form of personality disorder,²⁷ and sociological evidence

¹⁶ 1967 REPORT, *supra* note 2 at 212 (1967).

¹⁷ SCHUR, *supra* note 1 at 24.

¹⁸ Isbell, *supra* note 8 at 123.

¹⁹ LINDSMITH, OPIATE ADDICTION 87 (1947); SCHUR, *supra* note 1 at 22.

²⁰ Ploscowe, A.B.A.-A.M.A. JOINT REPORT, *supra* note 8 at 42 states:

If the drug is available, despite the mechanism of tolerance each addict eventually tends to find a level or a physical plateau in the use of the drugs. He tends to stop increasing the dosage at a point where he feels right physically and psychologically or where the drug will give him the euphoria that he is looking for.

²¹ However there is no evidence that consumption increases indefinitely, although it may level off for economic reasons.

²² "Habituation is the personality's emotional and psychological dependence on the drug in lieu of the more usual kinds of satisfactions." Winick, *supra* note 15 at 9.

²³ Vogell, Isbell and Chapman, *supra* note 6 at 1020.

²⁴ *Ibid.*

²⁵ See Clausen, *Social and Psychological Factors in Narcotics Addiction*, 22 LAW & CONTEMP. PROB. 34 (1957); Chien, *The Status of Sociological and Social Psychological Knowledge Concerning Narcotics*, in NARCOTIC DRUG ADDICTION PROBLEMS 146 (1963).

²⁶ LINDSMITH, *supra* note 19 at 165.

²⁷ Vogell, Isbell and Chapman, *supra* note 6 at 1020-21.

clearly shows that opiate addiction and illicit narcotic traffic flourish primarily in low-income, high crime rate, urban areas.²⁸ Testimony of addicts reveals that in the vast majority of cases, persons are introduced to drugs through association with friends, or even relatives (frequently spouses) for whom addiction is already a fact of life.²⁹ Rarely does the individual go out of his way to become addicted.³⁰ He is generally introduced to the drug by peers and his persistent use is a natural outgrowth of an environment which thrives on narcotics. In such an atmosphere, the addict is given no sociological motive for quitting drugs, because he functions in an environment where conformity is frequently identified with a state of addiction.

Admittedly there are a large number of persons living under similar conditions who do not fall prey to the drugs.³¹ This fact lends some support to the theory that addiction is primarily attributable to psychological disorder. The high ratio of personality maladjustment to addiction lends further support to this view. However, it would seem that such evidence alone is insufficient to demonstrate that psychological factors are the primary cause of addiction. The persons who succumb to addiction might do so because of more intensive pressure from peers rather than because they are addiction "prone". The high ratio might be the result of addiction leading to psychological disorder rather than the converse. Furthermore, although psychological state is undoubtedly causative to some degree, the question remains what underlying factors contributed to the development of that state. It is suggested that psychological factors are necessarily attributable to sociological status and environmental pressures. While none of these is the sole cause of drug addiction, the better evidence indicates that sociological considerations are the underlying, and thus the primary, explanations for its existence.

In addition to psychiatric dependence and environmental pressures, the addict labors under additional disadvantages. The first is the knowl-

edge of his status as a social undesirable. Practically without exception narcotic addiction is looked upon with repugnance, a sentiment reflected in legislation which makes most phases of addiction unlawful. Thus the addict lives in constant fear of apprehension by law enforcement personnel either for his use of drugs, or for some crime incidental to their use.

The narcotic user is a slave of the law of supply and demand of the illicit market. It is a well-documented fact that the price of drugs is so exorbitantly inflated that the vast majority of addicts cannot meet it with dollars obtained legally.³² They turn to petty crime—often involuntarily—and by doing so subject themselves to further possibility of prosecution. Thus the user functions in a state of criminality which also must have adverse psychological effects. Perhaps for him the only relief is to be found in the fear-allaying properties of the drugs themselves. If so, an unfortunately vicious circle is the result.

It is submitted that "habituation" is accomplished by an interaction of the psychological, legal, and sociological factors, with particular emphasis on the latter. No single factor is sufficient to explain it. Unfortunately, the sociological aspects of the problem greatly complicate the adoption of a suitable approach to treatment, since attention must be transferred from the individual addict to an entire segment of society. Nevertheless, such a refocusing is necessary since the unique characteristics of the social strata in which opiate addiction flourishes are largely responsible for introduction to and repeated use of narcotic drugs, and the resultant psychological compulsion of the addict to use them.

As already noted, determination of a state of physical dependence ordinarily depends on observation of the addict when he is denied drugs. It is not open to dispute that addiction may be seriously detrimental to the health of the user when the drugs upon which he depends are unavailable. At the very least, a true addict will suffer severe physical pain for days. However, an entirely distinct consideration of the addiction problem is the effect which the drug has on the physiology and behavior of the addict when his supply is maintained.

It is often stated that the general public is under a grave misconception as to the effects of opiate drugs upon the addict—believing that they are the

²⁸ See authorities cited note 25 *supra*.

²⁹ See Chien, *supra* note 25 at 153; See generally *Testimony of Mr. A, Mrs. B and Mr. C, Unidentified narcotic addicts, Hearings Before the Subcommittee on Improvements in the Federal Criminal Code of the Senate Committee on the Judiciary*, 1st Sess., pt. 5, 1600-17 (1955) [Hereinafter cited as *Hearings*].

³⁰ LINDSMITH, *supra* note 12 at _____. This view is directly opposed to the Theory that certain persons are "addiction-prone," seeking out and relying on the drug to combat emotional disorder.

³¹ Chien, *supra* note 25 at 148.

³² A.B.A.-A.M.A. JOINT REPORT, *supra* note 8 at 65.

cause of serious physiological damage and erosion of the nervous system, and the precipitant of violent, anti-social behavior.³³ Whether this misconception does in fact exist is open to some question. Although there are explanations for these misconceptions, it should be made clear at the outset that such beliefs generally are without factual basis.

There is extensive and competent medical evidence to the effect that introduction and maintenance of opiate drugs within the system is in no way physiologically harmful. It has been stated that "the addict under his normal tolerance of morphine is medically a well man. Careful studies of all known medical tests for pathological variation indicated, with a few minor exceptions, that the addict is a well individual when receiving satisfying quantities of a drug."³⁴ "It has not been possible to demonstrate that opiate drugs in themselves actually destroy tissue or are directly the cause of tissue deterioration."³⁵ While it is true that an overdose "may lead to respiratory failure, coma and death . . . , with dosages to which a person is tolerant, permanent organic damage does not occur."³⁶ Where demand for the drug is maintained, it may be relatively difficult even to determine that the addict is in a state of physical dependence. With the exception of the withdrawal symptoms, "there are no pathognomic physical signs of addiction"³⁷—and in "questionable cases, the only possible method of diagnosis may be isolation of the patient from the source of drugs and observation for signs of abstinence".³⁸

There is some ambiguity as to whether an addict whose dose is maintained is actually "normal". It has been stated that when morphine is administered, "a striking change is observed . . . a change which corresponds to the addict's subjective feeling that he has attained normalcy. The responses begin to fall into more normal categories. . . ." ³⁹ Furthermore, "some opiate users state that these agents do not impair, others state that they actually improve, their ability to do useful work. . . ." ⁴⁰ The example of the wealthy addict who maintains his habit for years without detec-

tion is often cited in support of this proposition. Nevertheless, the fact remains that opiates do have a narcotic effect, and as such will tend to induce drowsiness or cause inability to concentrate, apathy and lessened physical activity.⁴¹ It is suggested by some that a technical state of normalcy can never be achieved,⁴² and this is probably the better substantiated view. However, there is no doubt that an addict can function quite efficiently, with few exceptions.⁴³

These exceptions should be noted, since they are often responsible for the aforementioned misconceptions. Those directly caused by opiate use are depression of the appetite and of sexual drives.⁴⁴

Loss of appetite, in combination with the poverty of many addicts, often leads to an emaciated or depraved appearance which is improperly attributed to the drugs themselves. Such an appearance is the result of malnutrition.

Loss of sexual drive is cited to dispute the unfounded accusation that drugs induce sexual crimes.⁴⁵

A third symptom, indirectly related to opiate use is infection attributable to unsterile injection procedures. Subcutaneous injection is frequently accomplished with a safety pin and a dirty eyedropper, a method ideally suited to the development of serious infections.

A fact which may or may not be contrary to "popular" opinion is that persons under the influence of opiates are in no way stimulated to the performance of aggressive behavior.⁴⁶ To the contrary, opiate addicts are generally a rather docile lot, so long as their supply is maintained. The depressant properties of the drugs tend to curb action rather than inspire it, and there is simply no evidence that criminal activity is directly inspired by the physiological or psychological effects of an injection of narcotics.⁴⁷ But neither is it open to dispute that a large percentage of property crime is directly attributable to the existence of addiction.⁴⁸

⁴¹ 1967 REPORT, *supra* note 2 at 212.

⁴² Winick, *supra* note 15 at 14.

⁴³ See A.B.A.-A.M.A. JOINT REPORT, *supra* note 8 at 46-48 and authorities cited therein.

⁴⁴ Vogell, Isbell and Chapman, *supra* note 6 at 1023.

⁴⁵ SCHUR, NARCOTIC ADDICTION IN BRITAIN AND AMERICA 23 (1962).

⁴⁶ Winick, *supra* note 15 at 14; Wickler and Rasor, *supra* note 90 at 567-68.

⁴⁷ See generally Finestone, *Narcotics and Criminality*, 22 LAW AND CONTEMP. PROB. 69 (1957).

⁴⁸ *Id.* at 71; REPORT BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE—*The Challenge of Crime in a Free Society* 221-22 (1967) [hereinafter cited as 1967 REPORT].

³³ *Id.* at 45-46.

³⁴ *Id.* at 47.

³⁵ MAUER AND VOGEL, NARCOTICS AND NARCOTICS ADDICTION, 67 (1954).

³⁶ 1967 REPORT *supra* note 2 at 212.

³⁷ Vogell, Isbell and Chapman, *supra* note 6 at 1021.

³⁸ *Ibid.*

³⁹ NYSWANDER, THE DRUG ADDICT AS A PATIENT, 61 (1956).

⁴⁰ Wickler and Rasor, *Psychiatric Aspects of Drug Addiction*, AMER. JOUR. OF MED. 567-68 (May, 1953).

The addict whose craving is satisfied, and the same addict who faces the possibility of withdrawal is a two-fold personality. The satisfied addict is quite "normal"; the unsatisfied one is a desperate person. Moreover, the latter's physical and emotional problems are complicated by economic ones. Addiction is a very expensive habit, with daily costs estimated at \$5 to \$50 a day.⁴⁹ The peculiar nature of addiction often precludes the addict from holding a job long enough, or at high enough wages, to meet such an expense. The depressant effect of the drug may affect his efficiency;⁵⁰ the addict does not know when his system will demand the drug;⁵¹ and he lives in constant fear of being cut off from his supply, as well as being discovered by an employer or a police officer. Such circumstances are not conducive to a normal employment relationship.

The direct effects of the drug on his system do not stimulate the addict to criminal behavior. Unable to produce dollars lawfully, he is literally forced to turn to crimes—burglary, theft, prostitution, etc.—whose chief appeal is immediate monetary returns.⁵² Although the opiates them-

selves do not directly precipitate it, the amount of crime which is indirectly attributable to the fact of addiction is enormous.⁵³ This would appear to be the most unfavorable aspect of the problem of opiate addiction, especially since it serves the interests of the underworld entrepreneur who supplies the illicit market. Equally unfavorable is the physical suffering which the addict must undergo once he has become addicted and cannot maintain his supply. Perhaps surprisingly, the least unfavorable aspect of the problem is the effect which the drugs have on the body and behavior of the addict himself. This has been shown to be relatively slight.

Although the decision to rely on opiate drugs cannot be condoned, the fact cannot be avoided that the two most detrimental aspects of the opiate addiction problem—incidental crime and physical pain of abstinence—are attributable to the fact that for legal and economic reasons the drugs are not readily available. Yet such availability might induce further drug abuse. This obvious dilemma forms the basis of the controversy over legalized distribution to be considered at length below.

Barbiturates

The barbiturates are not opium derivatives. They are chemically distinguishable and, unlike the opiates, are widely manufactured and distributed throughout the United States for their legitimate medical use as sedatives, sleeping pills, and anesthetics. They are readily available by prescription, and illicit traffic in them appears to be quite distinct from the underworld traffic in heroin, although it has been alleged that some relationship may exist.⁵⁴

⁴⁹ It is difficult to accurately estimate an "average daily cost." Locale, availability and degree of addiction all affect the price of drugs. See generally 1967 REPORT, *supra* note 48 at 222. It is there stated that the average heroin user spends fifteen dollars per day—\$105 per week—on drugs. This figure represents approximately fifty dollars worth of stolen goods.

⁵⁰ *Id.* at 212 "An opiate may also produce drowsiness and cause inability to concentrate, apathy and lessened physical activity. It can impair mental and physical performance."

⁵¹ This is due to the fact that the drugs are so often diluted to an extent unknown to the user. One dose may be highly potent and thus last hours longer than another which has been cut considerably.

⁵² "The non-drug offenses in which the addict typically becomes involved are of the fund-raising variety." 1967 REPORT, *supra* note 48 at 222.

⁵³ See generally, 1967 REPORT, *supra* note 48 at 222.

⁵⁴ *Id.* at 218.

Barbiturates are quite similar to the opiates in their effect upon the user, and have been used as substitutes when the latter have been in short supply.⁵⁵ Like the opiates, they are physiological depressants and if taken chronically and in excessive amounts, will lead to both tolerance and physical dependence.⁵⁶ They are distinguishable by the fact that they do not produce psychological "euphoria", as do the opiates, but rather are emotionally depressing.⁵⁷ Also, the nature of the physical dependence which they produce is entirely different from that of the opiate drugs,⁵⁸ and the symptoms of withdrawal are markedly different and more severe—including convulsions and delirium with severe psychotic effects after abstinence.⁵⁹

⁵⁵ Isbell, *Clinical Research on Addiction in the United States*, in NARCOTIC DRUG ADDICTION PROBLEMS 127 (1963).

⁵⁶ Vogell, Isbell and Chapman, *Present Status of Narcotic Addiction*, 138 A.M.A.J. 1019, 1020 (1948).

⁵⁷ "Depressing" in the sense that they reduce anxiety and nervousness, dulling the senses rather than actively producing a state of well-being.

⁵⁸ Isbell, *supra* note 55 at 127.

⁵⁹ Winick, *supra* note 15 at 11; Vogell, Isbell and Chapman, *supra* note 56 at 1020.

The most important distinction is in the effects of the drug on the behavior of the user. While the opiates cause the user to approach a state of "normalcy"—even to the extent that addiction may be impossible to diagnose—the barbiturates, taken in excessive doses, may effect "impairment of judgment, loss of emotional control, staggering, slurred speech, tremor, and occasionally coma and death . . . They are also reported . . . to be implicated in assaultive attacks and automobile accidents".⁶⁰

It would appear that the barbiturates are cumulatively more dangerous than the opiates, in view of their ability to so seriously alter the consciousness of the user, rendering him incapable of normal self-control. In such a state he endangers himself as well as others. Furthermore, where a state of addiction is reached, abstinence effects are even more severe than those attributable to opiate withdrawal.

The black market traffic in barbiturates (as well as in amphetamines) is relatively new and only partially understood. Basically it consists of diversion from the chain of legitimate distribution.⁶¹ There is no evidence that the market is at all identified with the illicit opiate trade. There are indications, however, that barbiturate users cut across a wider segment of society, including college and high-school students.

The barbiturates differ from the opiates both in their physical and behavioral effects, and in their appeal to a different segment of the population. They present a problem related to but distinct from that attributed to opiate addiction.

Amphetamines

The amphetamine drugs (with trade names such as Benzedrine; Dexedrine) are entirely distinct from both the opiates and the barbiturates. They are physiological and psychological stimulants, used medically to combat fatigue, and mental depression. They have the capacity to produce the euphoric state of well-being characteristic of heroin, but physical dependence does not develop.⁶²

As stimulants, they produce a "high" in the user which, if the result of an excessive dose, may produce delusions or hallucinations. It is likely that they may, in addition, precipitate aggressive behavior—a result often improperly attributed to the use of heroin. It had been suggested that like the

barbiturates they are "implicated in assaultive acts",⁶³ and that "they contribute to criminal behavior, particularly among juveniles and young adults."⁶⁴ They are recognized as the frequent cause of fatal accidents in the trucking industry as well.⁶⁵

Since there is no evidence that "dangerous drug" users are forced to commit crime to pay for their supply, it may be concluded that such behavior is *directly* attributable to the effects of the drugs themselves. Like the barbiturates, amphetamines would appear to be more dangerous than the opiates per se.⁶⁶

Hallucinogens

The hallucinogens are probably the most bizarre of all narcotic and dangerous drugs, as well as the most harmful. They include peyote, mescaline, LSD and, more recently, STP,⁶⁷ and are distinguishable primarily for the extraordinary hallucinations or delusions which they produce. Peyote and mescaline are derivatives of a Mexican cactus plant and are not a major problem in this country.⁶⁸ However, LSD, a chemically produced synthetic (lysergic acid diethylamide), is much more potent than peyote and mescaline, and its usage is becoming increasingly widespread, especially among college students and "intellectuals"—a market entirely distinct from that of the opiates. Significantly the market seems to be less profit-oriented than that of heroin and other dangerous drugs.⁶⁹

The effects of hallucinogenic drugs are extreme. The user experiences vivid hallucinations; his sense of hearing becomes acute and his senses seem to blend so that sounds are felt and colors tasted. Images are seriously distorted. More seriously, the

⁶⁰ 1967 REPORT, *supra* note 48 at 214.

⁶¹ THE PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC DRUG ABUSE—*Final Report* 35 (1963) [hereinafter cited as 1963 *Final Report*].

⁶² Time, p. 69, col. 3 (May 5, 1967).

⁶³ The use of dangerous drugs is much more widespread than that of the opiates. It has been reported that the per capita consumption of dangerous drugs is "12 times as high as the consumption of narcotics . . ." New York Times, Feb. 5, 1967, p. 11, col. 1.

⁶⁴ "STP" appears to be the latest and most powerful hallucinogenic drug on the market, and is reported to have more serious, permanent, cumulative effects on its user. It is also said to include a substance which will obscure the chemical composition of the drug in the event of a spectrum analysis. McNeill, Village Voice, April 13, 1967, p. 8, col. 2 and see New York Times, June 28, 1967, p. 1, col. 3.

⁶⁵ Pescor, *The Problem of Narcotic Drug Addiction*, 43 J. CRIM. L., C. & P.S. 472, 473 (1952).

⁶⁶ 1967 REPORT, *supra* note 48 at 218.

⁶⁰ 1967 REPORT, *supra* note 48 at 214.

⁶¹ *Id.* at 217.

⁶² SCHUR, *supra* note 45 at 34.

user may be "dominated by feelings of paranoia and fear",⁷⁰ and repressions may be released which the individual is incapable of handling. The drug has the potential of producing prolonged psychoses, the acting out of character disorders, homosexual impulses, and suicidal inclinations. Its effects may last anywhere from four hours to days, though they may reappear weeks after use.⁷¹ The mental "euphoria" of the opiates is extremely mild in comparison.

Recent research has revealed that LSD may also be biologically damaging as well. There is evidence that the drug may damage the user's chromosomes by causing them to divide and rejoin abnormally.⁷² Such damage could result in the birth of abnormal or mentally retarded children, and there are indications that it might induce spontaneous abortion.⁷³

While a comprehensive understanding of the effects of the hallucinatory drugs is yet to be achieved, all indications are that it is the most damaging drug in use today. It is suspected that tolerance develops, although there is no evidence of physical addiction.⁷⁴ Unlike the opiates however, and to a greater degree than the barbiturates, the drug appears to render its user incapable of functioning normally. In addition, it may precipitate aggressive behavior by releasing repressions, as already noted. Finally, it may result in direct physiological damage. Its development suggests a serious and entirely new aspect of the problem of drug abuse.

Cocaine

Cocaine, like the amphetamines, is a stimulant. It is similarly non-addicting, in the physical sense, and tolerance to its use does not develop.⁷⁵ It is characterized by euphoria and excitement, but may also lead to paranoid delusions unpleasant to the user. It is sometimes used in combination with heroin to produce intensified euphoria without these effects.⁷⁶ It is known popularly as the "speed-ball" and as such is a commodity of the illicit opiate market. One author claims that "habitual use of cocaine alone can cause an addict to become epileptic. It can also cause severe brain dam-

age. . . . A mere pinch of the drug . . . turns a docile thief into a killer . . . and murder, instead of simple assault, is the easiest thing in the world."⁷⁷ These are strong accusations. If true, they would seem to indicate that cocaine is the most dangerous drug on the market. Fortunately, however, "cocaine has disappeared as a consequential drug"⁷⁸ and is presently "not the major drug of abuse that it once was"⁷⁹ due to unavailability, great expense, and the unpleasant side effects which accompany its use.

Marijuana

The use of marijuana is quite widespread with consumers found in both the opiate and college markets as well as in the artistic community and among young professional persons. Its effects are best described as "intoxicating". They combine both depression and stimulation, but are ordinarily classified as stimulants. They produce both exaltation and depression, depending frequently on the user's experience or state of mind, and occasionally produce hallucinations. Biologically, the effects of marijuana use are negligible—the worst being nausea and vomiting.⁸⁰ There is no valid evidence that it causes damage to the brain or nervous system, nor does it produce mental illness.⁸¹ There is no evidence that it either stimulates to violence or destroys internal restraints.⁸² "Tolerance is very slight, if it develops at all, and physical dependence does not develop."⁸³ It is suggested that its most damaging characteristic is that it becomes habit-forming and tends to disintegrate the personality, although it has been noted that it *might* contribute to crime by allaying the fear of a potential criminal.⁸⁴ Significantly there is no physiological relationship between marijuana and opiates. While many marijuana users admittedly graduate to later use of heroin, such a step is taken due to environmental and psychological pressures. "Marijuana purchasers are especially likely to encounter opiate peddlers, and the marijuana-using group may develop attitudes favorable to opiate use."⁸⁵

⁷⁷ SIRAGUSA, *THE TRAIL OF THE POPPY* 186-87 (1966); see also Pescor, *supra* note 68 at 472-73.

⁷⁸ Harney, *The Requirement for Law Enforcement in NARCOTIC DRUG ADDICTION PROBLEMS* 87 (1963).
⁷⁹ 1967 REPORT, *supra* note 48 at 213.

⁸⁰ *Ibid.*

⁸¹ Reichard, *Some Myths About Marijuana*, 10 FED. PROB. 15, 19 (Oct.-Dec. 1946).

⁸² *Id.* at 17.

⁸³ 1967 REPORT, *supra* note 48 at 213.

⁸⁴ Reichard, *supra* note 81 at 18.

⁸⁵ SCHUR, *supra* note 45 at 34.

⁷⁰ *Id.* at 215.

⁷¹ *Ibid.*

⁷² New York Times, Mar. 17, 1967, p. 46, col. 2.

⁷³ *Ibid.*

⁷⁴ 1967 REPORT, *supra* note 48 at 215.

⁷⁵ *Id.* at 213.

⁷⁶ SCHUR, *supra* note 45 at 32-33.

With the exceptions noted, it would appear that marijuana ranks low on the scale of adverse effects. While it alters consciousness, it apparently works little harm upon the user. It does not induce antisocial behavior, and it has no physiological relationship to subsequent opiate use. Alcoholic beverages, it has been said, are far more dangerous—an argument which seems to have some basis in fact. The problem which the use of marijuana presents appears to be different and far less serious than any of the other drugs discussed.

STATUTES

The Harrison Act of 1914 is the basic federal legislation dealing with narcotic drugs.⁸⁶ It is principally a tax statute, directed at the transfer of narcotics. Purchase, sale, dispensation, or distribution of narcotic drugs, except in the original stamped package indicating proper payment of tax, is made unlawful.⁸⁷ Issuance of the stamps is at the discretion of proper officials⁸⁸ and official order forms are required in all transactions.⁸⁹ Exempted are transactions between a patient and a registered physician "in the course of his professional practice" and for "legitimate medical purposes".⁹⁰ "Narcotic drugs" means opium, its compounds and derivatives, and cocaine.⁹¹ There is no reference in the act to narcotics addiction, which is not, and never has been, a federal offense.⁹²

The Marijuana Tax Act⁹³ passed in 1937, similarly prohibits the purchase, transport, possession, sale or dispensation of marijuana without payment of proper taxes, registration, and the use of special order forms⁹⁴.

The penalties for violations of both acts are severe; they are contained in the Narcotics Control Act of 1956.⁹⁵ Unlawful possession is punishable by two to ten years imprisonment and up to twenty thousand dollars fine for the first offense; a second offense may bring five to twenty years; third and subsequent offenses—ten to forty years. Penalties for unlawful sale are five to twenty years and a fine up to twenty thousand dollars for the

first offense; subsequent offenses may bring ten to forty years.⁹⁶ All minimum sentences are mandatory, leaving the trial judge without discretion. Convictions for sale or subsequent convictions for any other offense automatically preclude the granting of probation or suspension of sentence.⁹⁷

The Import and Export Act⁹⁸ regulates the flow of narcotic drugs into the United States. The act specifically prohibits the importation of opium for the purpose of manufacturing heroin. Accordingly, heroin has a rather special status in that it may not be lawfully imported or manufactured under any circumstances, so that all transactions in and possession of that drug are criminal per se.

The Opium Control Act⁹⁹ prohibits any production, transfer or possession of the opium poppy without license. Not surprisingly, no license has yet been granted under its provisions.¹⁰⁰

The Narcotics Manufacturing Act¹⁰¹ provides for licensing and production limitation of manufacturers of narcotics and their derivatives.

Finally, The Uniform Narcotic Drug Act¹⁰² also makes criminal the possession and sale of opium, its derivatives, cocaine, and marijuana, except as authorized under the act. Doctors or dentists are authorized to dispense narcotic drugs if done in good faith, and only in the course of their professional practice.¹⁰³ The act has been adopted as the control statute in most states,¹⁰⁴ including Illinois and New York.

The Illinois statute¹⁰⁵ is fairly typical of state legislation. Section 22-3 provides that no person shall manufacture, possess, control, sell or otherwise dispense any narcotic drug, except as authorized. Nor shall any person use or be under the influence of, or be addicted to the unlawful use of narcotic drugs.¹⁰⁶ A dentist or chiropodist is authorized to dispense drugs "in good faith and in the

⁸⁶ INT. REV. CODE OF 1954 § 7237 (a), (b).

⁸⁷ INT. REV. CODE OF 1954 § 7237 (c).

⁸⁸ 21 U.S.C. §§ 171-85 (1952).

⁸⁹ 21 U.S.C. § 188-188n (1952).

¹⁰⁰ 1963 *Final Report*, *supra* note 64 at 32.

¹⁰¹ 21 U.S.C. §§ 501-517 (1952).

¹⁰² 9B Uniform Laws Ann. 274.

¹⁰³ UNIFORM NARCOTIC DRUGS ACT §§ 7, 10.

¹⁰⁴ REPORTED BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE—*The Challenge of Crime in a Free Society* 213 (1967) [hereinafter cited as 1967 REPORT].

¹⁰⁵ Uniform Narcotic Drug Act, ILL. REV. STAT. ch. 38, § 22 (1965).

¹⁰⁶ ILL. REV. STAT. ch. 38, § 22-3 (1965). The provisions prohibiting addiction and state of influence were held invalid in *People v. Davis*, 27 Ill. 2d 57, 188 N.E. 2d 225 (1963). However non-medical "use" still remains an indictable offense.

⁸⁶ INT. REV. CODE OF 1954 §§ 4701-4736.

⁸⁷ INT. REV. CODE OF 1954 §§ 4704.

⁸⁸ INT. REV. CODE OF 1954 § 4702 (c) (1).

⁸⁹ INT. REV. CODE OF 1954 § 4705.

⁹⁰ INT. REV. CODE OF 1954 § 4705 (c) (1)

⁹¹ INT. REV. CODE OF 1954 § 4731.

⁹² 1967 REPORT, *supra* note 48 at 221.

⁹³ INT. REV. CODE OF 1954 §§ 4741-4762.

⁹⁴ INT. REV. CODE OF 1954 § 4755 (a) (1).

⁹⁵ INT. REV. CODE OF 1954 §§ 7237-7238.

course of his professional practice only".¹⁰⁷ However, a physician may only administer drugs to a patient suffering from a disease, ailment, injury or infirmities attendant upon old age, other than for addiction and only when he "in good faith" believes the disease requires such treatment and only for such time and in such quantity as is "reasonably necessary".¹⁰⁸

For purposes of the Act, "narcotic drugs" include opium and its derivatives, cocaine, marijuana, and a host of synthetics.¹⁰⁹ An addict is defined as one who "unlawfully uses any narcotic drug, or any person who has lost the power of self-control with reference to narcotic drugs and abuses the use of the narcotic drug to such an extent that the person or society is harmed".¹¹⁰

Conviction for sale is punishable by a term of ten years to life; subsequent offenses by life imprisonment. Probation or suspension of sentence are prohibited. Conviction for possession is punishable by a five thousand dollar fine and a minimum of two to ten years imprisonment; subsequent offenses may bring five years to life. No probation or suspension of sentence may be granted upon conviction of a subsequent offense.¹¹¹

Unlawful use is a misdemeanor providing for imprisonment of at least ninety days, but not to exceed one year. The ninety day minimum is mandatory. Probation may be required, not to exceed five years.¹¹²

Illinois has not yet enacted legislation establishing a program for the commitment of addicts convicted of criminal offenses.¹¹³ Accordingly, a person convicted of any of the above drug offenses is required to serve a sentence regardless of the fact that he may be addicted to drugs. Obviously addicts must use, possess, and are often economically compelled to sell narcotic drugs. Although not technically indictable for the "status" of addiction, they are constantly jeopardized by the unlawfulness of its necessary incidents.¹¹⁴

Although a number of states provide for voluntary and involuntary civil commitment,¹¹⁵ only

two, New York and California, provide for commitment in lieu of imprisonment of addicts charged with or convicted of criminal drug violations or other related crimes.

The self-expressed purpose of the New York provisions, which in their revised form went into effect on April 1, 1967, is to provide a "comprehensive program of compulsory treatment of narcotic addicts . . . as well as to discourage the violation of laws relating to the sale, possession and use of narcotics and other dangerous drugs".¹¹⁶ Significantly, The Narcotic Drug Control Act¹¹⁷ remains in effect. Possession and sale of drugs thus remain criminal acts punishable under the Penal Code.¹¹⁸ The accused faces imprisonment unless he qualifies for commitment under the new procedure.

Sections 200 through 206 of New York's Mental Hygiene Law provide for voluntary or involuntary civil commitment generally.¹¹⁹ Sections 207 through 217 of the new law deal exclusively with persons charged with a criminal violation who may qualify for commitment by reason of their addict status.

Any person convicted of a violation of the possession or sale provisions of the Penal Code, or of a felony or misdemeanor, or the offense of prostitution, who states that he is, or appears to be, a narcotic addict while in custody shall undergo medical examination to determine whether he is such an addict.¹²⁰ He shall not be sentenced prior to the court's review of the medical evidence. The court may determine that he is not an addict and proceed to sentence under the penal law. Determination will take place at a hearing, without a

¹¹⁶ N.Y. MENTAL HYGIENE LAW § 200-2 (Supp. 1967).

¹¹⁷ N.Y. PUBLIC HEALTH LAWS §§ 3300-66 (1954). Modeled after the Uniform Narcotic Act, the law is similar to the Illinois statute, with exceptions. "Use" is not an offense in New York. Physicians are not so explicitly restricted: "A physician or a dentist, in good faith and in the course of his professional practice only may prescribe, administer and dispense narcotic drugs . . ." N.Y. PUBLIC HEALTH LAWS § 3330 (1954).

¹¹⁸ N.Y. Penal Code §§ 1747-51 have been recently revised and are incorporated in the New Penal Code §§ 220-220.45. The degrees of sale and possession have been defined and some penalties have been increased. It has been suggested however that the revision "has achieved little more than a restatement of existing penal provisions." di Suvero, *Drug Offenses and the New Penal Law*, 32 BROOKLYN L. REV. 287, 292 (1966).

¹¹⁹ These provisions will not be discussed. Since this article is concerned primarily with the "criminal" addict, voluntary and involuntary commitment programs applicable to persons not charged with a crime are beyond its scope.

¹²⁰ N.Y. MENTAL HYGIENE LAWS § 207 (Supp. 1967).

¹⁰⁷ ILL. REV. STAT. ch. 38 § 22-11 (1965).

¹⁰⁸ *Ibid.*

¹⁰⁹ ILL. REV. STAT. ch. 38 § 22-2-17 (1965).

¹¹⁰ ILL. REV. STAT. ch. 38 § 22-2-18 (1965).

¹¹¹ ILL. REV. STAT. ch. 38 § 22-40 (1965).

¹¹² *Ibid.*

¹¹³ Although the Illinois legislature is currently considering a bill which would provide for commitment —5,671, 75th G. A. (1967), discussed below.

¹¹⁴ See generally 1967 REPORT, *supra* note 104 at 221.

¹¹⁵ See note, 8 ST. LOUIS U. L. J. 579, n. 86.

jury, at which either party may present relevant evidence, the burden of proof of addiction being upon the State. If the defendant is found to be a narcotic addict, and has been convicted of a *misdemeanor* or *prostitution*, he must be certified to the "care and custody" of the narcotics commission for an indefinite period, which shall terminate either upon his discharge by the commission as rehabilitated or upon the expiration of thirty-six months.¹²¹ If the defendant has been convicted of a *felony*, the court must *either* sentence him in accordance with the penal law applicable to such felony, or certify him to the commission for an indefinite period terminating either upon discharge by the commission, or the expiration of five years (whichever occurs first).¹²² The addict does not elect commitment. It is an alternative to imprisonment granted at the discretion of the court. The provisions do not apply if the authorized sentence for the crime is death or life imprisonment.

Section 210 of the new act provides for civil commitment of an accused *prior* to trial and conviction. Where the defendant is under indictment for a felony, misdemeanor or prostitution, he may petition the court for civil certification as an addict under the procedures of Section 206. A defendant is eligible for civil certification if (1) he has not previously been convicted of a felony; (2) he has not previously been certified by the commission; (3) the charge against him is not punishable by death or life imprisonment; (4) the district attorney consents to such certification if the charge is a felony.¹²³ If the petition is granted, the criminal charge is dismissed. If denied, the criminal charge is tried, subject to the already described procedures of Section 208.

The California procedure for commitment of addicts charged with crime is similar to that of New York, with notable exceptions. In California, the addict charged with a crime is eligible for commitment,¹²⁴ unless he is charged with or has been previously convicted of certain enumerated felonies or a possession and sale offense for which the minimum prescribed penalty exceeds five years.¹²⁵ Accordingly, first offenders on charges of posses-

sion of narcotics¹²⁶ or marijuana¹²⁷ are clearly eligible, while persons charged with sale are ineligible since all sale offenses involve minimums in excess of five years.¹²⁸ However, unlike New York, California provides for the exercise of judicial discretion. "In unusual cases, wherein the intent of justice would best be served, the judge may, with the concurrence of the district attorney and defendant, order commitment notwithstanding Section 3052."¹²⁹ In felony cases the court has counter-balancing discretion to *deny* commitment, even though the defendant may be technically eligible, where "in the opinion of the judge the defendant's record and probation report indicates such a pattern of criminality that he does not constitute a fit subject for commitment under this section".¹³⁰

The Illinois legislature is currently considering passage of a commitment statute. Under the proposed bill¹³¹ an addict charged with or convicted of a crime may elect treatment prior to trial or subsequent to his conviction.¹³² He is ineligible for the program: if the crime for which he is being tried is a "crime of violence";¹³³ if he is charged with the sale of narcotic or dangerous drugs; if he has two or more previous convictions of a crime of violence; or if he has other criminal proceedings for felony pending against him. If committed prior to trial, charges will be dismissed upon successful completion of treatment for a period not to exceed two years. If committed subsequent to conviction, he may be confined for a period "not to exceed the maximum sentence that could be imposed for his conviction or five years, whichever is less".¹³⁴ An

¹²⁶ CAL. HEALTH & SAFETY CODE § 11500.

¹²⁷ CAL. HEALTH & SAFETY CODE § 11530.5.

¹²⁸ CAL. HEALTH & SAFETY CODE §§ 11500, 11501, 11531.

¹²⁹ CAL. WELFARE & INSTITUTIONS CODE §§ 3050-51 (1965). Section 3052 prescribes limitations on eligibility.

¹³⁰ CAL. WELFARE & INSTITUTIONS CODE § 3051. Thus in "unusual" cases even a second offender in a possession or sale case would be eligible for commitment at the discretion and concurrence of both the judge and the District Attorney.

¹³¹ S. 167, 75th G. A. (1967).

¹³² Unlike in New York, the convicted addict may not be committed unless he *elects* it in lieu of imprisonment.

¹³³ "Crimes of violence" include treason, murder, voluntary manslaughter, rape, robbery, arson, kidnapping, aggravated battery and any other felony which involves the use or threat of physical force, ILL. REV. STAT. ch. 38 § 2-8 (1965). Burglary, ordinarily a "crime of violence" is specifically excluded under the provisions of S.671.

¹³⁴ S.167, 75th G. A. § 10 (1967).

¹²¹ N.Y. MENTAL HYGIENE LAW § 208 (Supp. 1967).

¹²² *Ibid.*

¹²³ N.Y. MENTAL HYGIENE LAW § 210 (Supp. 1967).

¹²⁴ CAL. WELFARE & INSTITUTIONS CODE §§ 3050-51 (1965).

¹²⁵ CAL. WELFARE & INSTITUTIONS CODE § 3052 (1965).

addict charged with a crime can be committed for treatment only with the consent of the state's attorney. There are no provisions for judicial discretion.

The new federal commitment statute¹³⁵ provides that a person charged with a crime may elect civil commitment *prior* to trial if he is determined to be a narcotics addict and is otherwise eligible. He is ineligible if (1) he is charged with a crime of violence;¹³⁶ (2) he is charged with import or sale of a narcotic drug; (3) he has a prior felony charge pending against him or is currently serving sentence for such a charge (including probation); (4) he has been convicted of a felony on two or more occasions. If eligible and he elects to be committed criminal charges will be dropped upon successful completion of a commitment program not to exceed thirty-six months duration.¹³⁷

A person determined to be an addict may also be eligible for commitment in lieu of sentence *subsequent* to conviction on a criminal charge. The eligibility requirements are identical to those of pre-trial commitment with two exceptions: (1) if the person was convicted of unlawful sale of a narcotic drug, he may still be eligible "if the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug"¹³⁸; (2) the offender is ineligible if previously committed under any state or federal proceedings on three or more occasions. If the court determines that the defendant is eligible and is likely to be rehabilitated, he will be committed for an indeterminate period not to exceed ten years or the maximum sentence

which could otherwise be imposed.¹³⁹ He may be conditionally released upon proper certification, but not within a six month period.¹⁴⁰

Under the Harrison Act, the Uniform Narcotics Act, and the state statutes modeled after them, the drug addict is dealt with severely. Although the status of addiction may not be made unlawful,¹⁴¹ the fact remains that use, possession and sale of narcotic drugs are frequently incident to such a status, and all are offenses subject to harsh mandatory penalties. Thus a person might be imprisoned for years, not as punishment for his addiction, but certainly because of it. The statutes do not distinguish between possession for purposes of sale and possession for personal use. They do not distinguish between sale for purposes of profit and sale necessary to support the habit. The addict who is arrested with a tin of heroin sufficient to maintain him for a day is just as guilty of possession as the non-addict peddler who possesses only to resell at a huge profit, and has no habit to maintain. Under the statutes the judge is allowed no sentencing discretion once the state has proved its case. Thus discretion is left to the prosecutor entirely.

Enactment of the commitment statutes indicates a clear recognition that the addict who is a "criminal" under the provisions of the uniform acts should not be punished for his crime, but should be treated as diseased and institutionalized for care. Whether they achieve this objective remains to be seen. At the least they serve to point out the important distinction between the addict who must commit crime by reason of his addiction, and the non-addict who sells drugs solely for profit.¹⁴²

Enforcement and Interpretation

It has recently been stated that the objectives of narcotics law enforcement "are to reach the highest possible sources of drug supply and to seize

the greatest possible quantity of illicit drugs before use."¹⁴³

Implied in this statement is the underlying aim of destroying the illicit market and ultimately the entire menace of drug abuse. Notably absent is the objective of punishing the addict.

There is serious doubt whether enforcement of present statutes, in particular the uniform nar-

¹³⁵ THE NARCOTIC ADDICT REHABILITATION ACT, 18 U.S.C. 4251-55 (Supp. 1967), 28 U.S.C. 2901-06 (Supp. 1967), 42 U.S.C. 3401 (Supp. 1967).

¹³⁶ Crimes of violence include: "voluntary manslaughter, murder, rape, mayhem, kidnapping, robbery, burglary, or housebreaking in the nighttime, extortion accompanied by threats and violence, assault with a dangerous weapon or assault to commit any offense punishable by imprisonment for more than one year, arson punishable as a felony, or an attempt to conspire to commit any of the foregoing offenses." 28 U.S.C. 2901 (c) (Supp. 1967).

¹³⁷ 28 U.S.C. §§ 2901-2 (Supp. 1967).

¹³⁸ 18 U.S.C. § 4251 (e) (2).

¹³⁹ 18 U.S.C. § 4253 (a). This section is not applicable if appropriate facilities are unavailable.

¹⁴⁰ 18 U.S.C. § 4254.

¹⁴¹ Robinson v. California, 370 U.S. 660 (1962).

¹⁴² See generally REPORT BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, Task Force Report: The Courts 101 (1967).

¹⁴³ 1967 REPORT, *supra* note 111 at 218.

cotics laws, has been effective. Seizure is rare, there is no evidence that drug abuse is declining, the rate of relapse is extremely high, the illicit market still flourishes, and rarely are the underworld "kingpins" apprehended. Prisons are full of addicts who must suffer the severity of mandatory penalties ideally intended for those who continue to supply the market at immense personal profit.

It is very roughly estimated that 3,000 pounds of heroin are smuggled into the United States annually.¹⁴⁴ Of this amount the Customs and Narcotics Bureaus together seized slightly less than 300 pounds in 1963¹⁴⁵ and a total of 343 pounds in 1965¹⁴⁶—only about 10% of the total supply. The failure of both Commissions, as currently staffed, has been recognized by at least three investigative commissions which have considered the problem.¹⁴⁷ Although there is unquestionably less heroin flowing into the country today than there was before passage of the Harrison Act, the fact remains that the seizure objectives are not lately being accomplished.

The question whether the incidence of drug abuse is increasing or decreasing is a controversial one. There is no question that abuse of the "dangerous" drugs, including the hallucinogens, is becoming more widespread.¹⁴⁸ This fact is not surprising in light of the ready availability and the comparative lack of legislation regulating their transfer and use. Prevalence of addiction to opiates however, is more difficult to determine. The Bureau of Narcotics estimates, based on the number of persons arrested and subsequently registered with the Bureau, indicate that there are as many opiate addicts in 1966 as there were in 1965.¹⁴⁹ It can be

argued therefore that the per capita incidence has declined. There are indications however that the Bureau figures are not an accurate reflection of the problem, and other estimates of the number of addicts have gone much higher.¹⁵⁰ Considering the method of computation, it is likely that there are more addicts than the Bureau's figures indicate. The only safe observation that can be drawn is that there is no competent evidence that opiate addiction has declined or that narcotic violations have been less frequent since 1956—the year that Congress determined that increased mandatory penalties were the only deterrent to such violations.¹⁵¹ It is submitted that no matter how severe the penalty, the underworld will take the risk in view of the profits to be made, and the addict will take it and suffer the consequences because he has no choice.¹⁵²

It has recently been observed by a Presidential Commission organized to study the problem "that organized criminals in the United States are heavily involved in the illegal importation and distribution of narcotic and dangerous drugs, but they have to a disturbing extent shielded themselves from arrest and prosecution."¹⁵³

There is little doubt that the user and the addict

(1955) [hereinafter cited as *Hearing*]. As of Dec. 31, 1965 the Bureau listed a total of 57,199 active opiate addicts (52,793 heroin users included).

¹⁵⁰ The Commission on Narcotic and Drug Addiction reported in 1963:

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. 1963 *Final Report*, *supra* note 144 at 4.

It has been stated that it "is impossible to give any exact estimate of the number of drug addicts in this country . . ." Ploscowe, *Some Basic Problems in Drug Addiction and Suggestions for Research*. A.B.A.—A.M.A. JOINT COMMITTEE REPORT ON NARCOTIC DRUGS—*Drug Addiction: Crime or Disease?* 27 (1961) [Hereinafter cited as A.B.A.—A.M.A. JOINT REPORT]; for a comprehensive discussion see LINDSMITH, *THE ADDICT AND THE LAW* 99–134 (1965).

¹⁵¹ "The committee has arrived at the conclusion that there is need for a continuation of the policy of punishment of a severe character as a deterrent to narcotic law violations. It therefore recommends an increase of maximum sentences for first as well as subsequent offenses." REPORT OF THE INTERDEPARTMENTAL COMMITTEE ON NARCOTICS TO THE PRESIDENT. 16 (Feb. 1956).

¹⁵² "The compulsion to take the drug cannot be stopped by a threat of jail or prison sentences." A.B.A.—A.M.A. JOINT REPORT, *supra* note 150 at 44.

¹⁵³ PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE—*Interim Report* 8 (April 1, 1963).

¹⁴⁴ THE PRESIDENT'S ADVISORY COMMISSION ON NARCOTIC AND DRUG ABUSE—*Final Report* 37 (Nov. 1963), hereinafter cited as 1963 *Final Report*.

¹⁴⁵ *Id.* at 5.

¹⁴⁶ 1967 REPORT, *supra* note 104 at 217.

¹⁴⁷ The Commission on Narcotic and Drug Abuse observed that a total of 729 Customs Port and Criminal Investigators were responsible for some 160 million persons entering the country legally each year, and recommended a doubling of the number of such officers stating that "effective customs enforcement in narcotics is virtually impossible with a force of this size." 1963 *Final Report*, *supra* note 144 at 38. However in 1966 there were only 768 such investigators, an increase of forty persons. 1967 REPORT, *supra* note 104 at 217.

¹⁴⁸ 1967 REPORT, *supra* note 104 at 215.

¹⁴⁹ H. J. Anslinger, Commissioner of Narcotics, reported that there were between 50 and 60 thousand addicts in 1955. *Hearings Before the Subcommittee on Improvement in the Federal Criminal Code of the Senate Subcommittee on the Judiciary*, 1st Sess., pt. 1, p. 10

have become the scapegoat of the enforcement agencies.¹⁵⁴ More than forty per cent of the cases prosecuted by the Narcotics Bureau involved addicts who happened to be peddlers, and the Presidential Commission on Law Enforcement recently observed that the percentage of addicts prosecuted by the state is probably even higher.¹⁵⁵ Indeed, one municipal judge estimated that 99% of the persons charged with illegal possession and sale in New York City over a five year period were drug users.¹⁵⁶ Courts have explicitly sanctioned the imprisonment of an admitted addict for possession of heroin in such quantity as to indicate that it was for his own use,¹⁵⁷ and the prisons and jails are crowded with addicts,¹⁵⁸ some of whom die there due to forced withdrawal.¹⁵⁹

Another generally recognized yardstick of statutory effectiveness is the rate of relapse. Effective law and punishment is ideally deterrent and rehabilitative, as well as punitive. Estimates of relapse rates among addicts range as high as 95%¹⁶⁰ although variables such as degree and permanency of the relapse must be taken into account. The true rate is probably somewhat lower, although there is no question that the percentage is at least 50%.¹⁶¹ Not only do threats of imprisonment away from drugs fail to deter drug abuse, imprisonment itself fails as well. The system has been caustically termed the "revolving door" approach.¹⁶² Imprisonment, release, relapse, imprisonment, is an unending cycle.

These facts are the result of strict compliance

¹⁵⁴ 1967 REPORT, *supra* note 104 at 219.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Hearings, supra* note 149 at pt. 5, p. 1348. Hon. Jonah J. Goldstein, Judge, Court of General Sessions, New York, testifying:

The probation department of the court of general sessions tabulated the figures for the last five years of persons charged with illegal possession and sale of narcotics, 99% of whom were drug users."

¹⁵⁷ *People v. Zapata*, 34 Cal. Rptr. 171, 230 Cal App. 2d 903 (1963). Of the 23,000 narcotics arrests in 1954 it is unlikely that all were peddlers only. Many were undoubtedly addicts who possessed or sold to support their habit and were thus arrested.

¹⁵⁸ See generally, Bennett, *A Prison Administrator Views Today's Narcotics Problem*, in NARCOTIC DRUG ADDICTION PROBLEMS 159 (1963).

¹⁵⁹ See e.g., *Hearings, supra* note 149 at pt. 2, 554-55 (1955).

¹⁶⁰ REPORT BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE—*The Challenge of Crime in a Free Society* 226 (1967) [Hereinafter cited as 1967 REPORT].

¹⁶¹ See generally A.B.A.-A.M.A. JOINT REPORT, *supra* note 150 at 88-92 and authorities cited therein.

¹⁶² Goldstein, in *Hearings, supra* note 149 at pt. 5, 1350.

with statutory provisions. Ideally aimed at the peddlers-for-profit and the underworld kingpins, the uniform narcotics acts fail to distinguish them from the addict peddler and possessor, who thus fall within their purview. It appears that enforcement has been diverted to the addict himself—perhaps unwittingly or out of desperation to produce some results—but certainly without justice.

Trial courts have been accused of "playing God" in an attempt to evade the strictures of mandatory minimum penalties,¹⁶³ and it has been observed that some judges advise defendants to plead guilty to lesser charges of possession rather than risk the penalties of a sale conviction.¹⁶⁴ Whether such acts are deemed an abuse of judicial discretion or a necessary means of reaching a just result, it is unfortunate that judges must disregard the law at all. Such judicial conduct is strong evidence that present laws are frequently incapable of just application.

It is doubtful that the "objectives" of narcotics law enforcement are capable of accomplishment under present legislation. Indeed, possession, sale and the use of drugs are offenses limited almost exclusively to the addict population to the extent that they are enforced. Although the use of drugs cannot be condoned, it is submitted that in certain circumstances, possession and sale of such drugs should not be punishable. Indeed, punishment of such acts may be subject to constitutional infirmities.

In *Robinson v. California*,¹⁶⁵ the Supreme Court struck down a California statute which made it a crime to be addicted to the use of narcotics,¹⁶⁶ explicitly recognizing the addiction is a disease, punishment for which is cruel and unusual and therefore in violation of the fourteenth amendment. So holding, however, the Court stated that punishment for use alone would not violate eighth amendment guarantees.¹⁶⁷

In dissent, Justice White pointed out the possible inconsistency in the majority's position, questioning how "use"—which is a necessary incident of the status of addiction—may be punishable without also violating the eighth amendment.¹⁶⁸

¹⁶³ SIRAGUSA, *THE TRIAL OF THE POPPY* 210 (1966).

¹⁶⁴ Lindesmith, *supra* note 150 at ____.

¹⁶⁵ 370 U.S. 660 (1962).

¹⁶⁶ The statute, CALIFORNIA HEALTH & SAFETY CODE § 11721 provided in part: "No person shall use, or be under the influence of, or be addicted to the use of narcotics . . ." The constitutionality of being "under the influence of narcotics" was not at issue.

¹⁶⁷ 370 U.S. at 666 (1962).

¹⁶⁸ *Id.* at 688 (White, J. dissenting).

The use distinction made by the majority has been criticized as "unpersuasive" and "untenable".¹⁶⁹ It is submitted, however, that the distinction is a valid one. It would seem that where use is *incident to the maintenance of a state of addiction*, its punishment would also violate the premise of *Robinson*, that addiction is a disease. In effect, where punishment for an act incident to disease indirectly punishes for the disease, it would be subject to constitutional infirmity. However, where use is not incident to a true state of addiction, it would be permissible.¹⁷⁰

If the Court should ever hold that incident use may not be punished, it would appear that for purposes of consistency, punishment for necessarily incident possession and sale would have to be

similarly struck down.¹⁷¹ Such a ruling would serve to bring the provisions of the Harrison and Uniform Narcotic Acts into conformity with the recently enacted federal commitment statute which explicitly recognizes that an addict who sells drugs for the primary purpose of supplying his requirement, if otherwise eligible, shall be committed rather than punished.¹⁷² Such a decision would force a revision of the narcotics acts to exclude from their scope entirely the diseased addict whose criminal actions are attributable to his condition. Furthermore, he would no longer be subject to the oppression of harsh mandatory penalties never properly intended for him in the first place.

Operation and Effects of Commitment Programs

An adequate program for dealing with the problem of drug abuse should accomplish two distinguishable objectives: the humane treatment and possible cure of drug addicts,¹⁷³ and the severe punishment of narcotics profiteers and eventual destruction of the market in which they operate.

The uniform acts, as presently drafted and enforced, do not accomplish the first objective and are of doubtful efficacy as to the second. The commitment statutes theoretically attempt to remedy the treatment shortcoming. To do so they must act by way of exception to the blanket provisions of the uniform acts—supplementing rather than replacing them. Accordingly, they are subject to innumerable procedural restrictions which prevent their effective operation. Furthermore, they

are not intended to accomplish the second objective at all.

The first issue raised by all the statutes is whether they merely afford alternative forms of punishment. The Federal statute explicitly provides:

It is the policy of the Congress that certain persons charged with or convicted of violating Federal criminal laws who are determined to be addicted to narcotic drugs . . . should in lieu of prosecution or sentencing, be civilly committed for confinement and treatment designed to effect their restoration to health and return to society as useful members.¹⁷⁴

New York similarly refers to "disease" and "treatment"¹⁷⁵ and the California statute states that "such treatment shall be carried out for non-punitive purposes."¹⁷⁶

Any person committed to these programs may be discharged as rehabilitated at the discretion of the officer in charge after a minimum period has elapsed. However, under the federal statute a person may be required to serve as long as ten years,¹⁷⁷ under the New York statute three to five years,¹⁷⁸ under the California statute seven years,¹⁷⁹ and under the proposed Illinois provisions, five

¹⁶⁹ di Suvero, *supra* note 118 at 295.

¹⁷⁰ Non-incident use contemplates the situation where the user is not an addict in the physical sense. The distinction would be aimed at discouraging experimentation with drugs.

A possible inconsistency in this position is that the person who merely uses drugs without reaching a state of dependence is subject to penalty, while the more "culpable" individual who has disregarded the law and abused drugs more often is treated. The inconsistency is inevitable in light of the state's right to regulate use by trying to discourage experimentation.

¹⁷¹ See generally, di Suvero, *supra* note 124 at 294-96.

¹⁷² The Narcotic Addict Rehabilitation Act of 1966, *supra* note 135, provides in part: ". . . unless the court determines that such sale was for the primary purpose of enabling the offender to obtain a narcotic drug which he requires for his personal use because of his addiction to such drug." 18 U.S.C. 4251 (f) (Supp. 1967).

¹⁷³ It is recognized today that addiction is a unique form of disease.

¹⁷⁴ 42 U.S.C. 3401 (Supp. 1966).

¹⁷⁵ N.Y. MENTAL HEALTH LAW §§ 200-1-2 (Supp. 1967).

¹⁷⁶ CAL. WELFARE & INSTITUTIONS CODE § 3000 (1965).

¹⁷⁷ 18 U.S.C. 4253 (a) (Supp. 1967).

¹⁷⁸ N.Y. MENTAL HYGIENE LAW § 208-4 (a)-(b) (Supp. 1967).

¹⁷⁹ CAL. WELFARE & INSTITUTIONS CODE § 3201 (1965).

years.¹⁸⁰ In view of evidence to the effect that the suggested period for treatment rarely exceeds one year, and is ordinarily established at four to five months,¹⁸¹ a confinement of five to ten years would appear to be medically unrealistic and inconsistent with "treatment designed to effect their restoration to health and *return to society as useful members.*" Such a confinement could serve no medical function; it would have to be punitive in nature.

It is possible that the statutes exclude from their scope those persons for whom they should be intended. The federal statute and the Illinois proposals both deny eligibility for pre-trial commitment to addicts charged with sale.¹⁸² The Illinois statute would exclude persons so charged from post-conviction eligibility as well. In view of the fact that addicts are frequently peddlers, the Illinois proposals are especially unrealistic, and it is not apparent why an addict so charged should be excluded from pre-trial commitment under either statute. The same criticisms apply to the California statute which denies eligibility to any persons charged with or convicted of a drug offense carrying with it a minimum penalty of five years' imprisonment.¹⁸³ Under it sale offenders and second-time possession offenders are automatically excluded. Addict peddlers and possessors most often suffer the injustice of the narcotics laws. They are most in need of the protection afforded by the commitment exceptions, but are denied it by reason of the sale exclusions.

The federal act also denies eligibility to persons convicted of a felony on two or more prior occasions.¹⁸⁴ The Illinois proposal makes a similar exclusion for persons convicted of "crimes of violence" on two or more prior occasions. It is not apparent why prior convictions should preclude eligibility. Assuming that the objective of the statutes is medical rehabilitation and not punishment, it certainly cannot be said that a prior offender is less "likely to be rehabilitated" (and thus ineligible) in a medical sense merely by reason of his past offenses, no matter how serious they were. Such an exclusion is inconsistent with the principle of the statutes.

Under the federal program, any person convicted of a crime of violence is ineligible. This designation

includes burglary, and housebreaking and assault with intent to commit any offense punishable by imprisonment for more than one year. As indicated above, the commission of crimes capable of yielding quick financial returns is often attributable—like sale—to addicts. The federal statute states that addicts should be committed rather than punished for certain crimes, yet this provision excludes them for crimes for which they are most frequently convicted. Such a provision is self-defeating.

The statutory deficiencies cut both ways. The New York provisions suffer a flaw characteristic of all the statutes, which works to the disadvantage of the state rather than the addict. None of the statutes provide that the accused show that the crime for which he was either charged or convicted was in fact attributable to his addicted state.¹⁸⁵ Accordingly, he may rely on his status to escape punishment for a sale, possession or other monetary crimes committed for reasons entirely unrelated to the disease. The statutes should be directed at commitment of the addict who possesses, sells or commits crime in order to pay for his drug supply. Addicts who intentionally commit crime for reasons *unrelated* to their addiction, or who sell drugs for profits in excess of those required to sustain their requirements should not be within their scope. Such persons should be tried and punished without benefit of commitment, on the reasoning that punishment is justified either because the crime is unrelated to the disease, or because it is so serious that the fact of disease does not sufficiently offset the social interest in punishment.

The most favorable contribution which the commitment statutes make is the recognition that addiction is a form of disease and that certain acts which are ordinarily "criminal" are not justifiably punishable if attributable to that disease. Although the statutory deficiencies noted raise the question whether present statutes treat addicts in a manner consistent with this fact, there are a number of provisions which should properly be included in any proposal for an effective commitment program.

The most significant is the New York provision which denies eligibility for post-conviction treatment *only* to those convicted of a crime punishable by death or life imprisonment.¹⁸⁶ Accordingly no person is denied eligibility by reason of conviction

¹⁸⁰ S.167, 75th G. A. §10 (1967).

¹⁸¹ A.B.A.-A.M.A. JOINT REPORT, *supra* note 150 at 87.

¹⁸² 28 U.S.C. 2901 (9) (2) (Supp 1967); S. 671, 75th G. A., § 8 (1967).

¹⁸³ CAL. WELFARE & INSTITUTIONS CODE § 3052.

¹⁸⁴ 28 U.S.C. § 4251 (4) (4) (Supp 1967).

¹⁸⁵ See generally 1967 REPORT, *supra* note 160.

¹⁸⁶ NEW YORK MENTAL HYGIENE LAW § 208-1 (Supp. 1967).

for any sale or possession offense. As indicated, such a provision is essential to the effect implementation of commitment objectives. The federal statute similarly recognizes this fact by permitting eligibility where the sale is for maintenance purposes;¹⁸⁷ nor is any person excluded by reason of a possession conviction under any of the federal provisions.

The California statute is most noteworthy for its unequivocal provision for judicial discretion in *all* commitment proceedings. Although sale and certain other crimes do preclude eligibility, the court may waive the limitation at its discretion, in "unusual" cases.¹⁸⁸ The absence of judicial discretion with respect to narcotics violation is one of the most serious shortcomings of present drug law; provisions for its exercise are necessary.

Although they are effective to a degree, it is submitted that the new commitment statutes are seriously in need of revision even as they go into effect. As enacted, they are simply too exclusive and the "treatment" which they provide is questionable. One solution would be to eliminate the exclusion sections entirely, and provide eligibility for *any* addict charged with or convicted of a crime—if it is shown to be attributable to his state of addiction—with exceptions only at the discretion of the court.

An alternative solution has already been suggested, and would accomplish the same end with relative ease: amend the uniform narcotics acts to provide severe punishment for non-addict sellers and others who peddle for profit, and make *incident* sale and possession a distinct offense for which the addict would be committed. In turn

the commitment statutes could be simplified and would no longer have to act by way of exception, although their maximum allowable confinements would have to be reduced considerably to bring them more in line with the realities of medical treatment.

The second alternative would seem the more suitable. Under it, the threat of imprisonment for addicts forced to sell to support their habit would be virtually non-existent and they would no longer be committing a felony by selling for that purpose. They would be imprisoned only in exceptional cases, at the discretion of the court. Provisions for commitment upon conviction of a non-drug offense, shown to be incident to the addiction, would remain in the commitment statutes, thereby providing an additional safeguard. In this manner the humane treatment of opiate addicts would be accomplished successfully.

The most effective program for civil commitment however does not effect the second objective of narcotics enforcement: the reduction and eventual dissolution of the illicit market. Dissatisfaction with the failure of present legislation to deal with this real source of drug abuse, coupled with a serious dispute as to whether any mandatory institutional program can "cure" addiction, has led to serious proposals for the legal distribution—through private physicians or clinics—of opiate drugs. The principle has been praised and damned by competent authorities—lawyers, doctors and sociologists alike. It is an intriguing method of eliminating the illicit market as well as treating the addict humanely. As such it deserves careful consideration.

Legalized Distribution

The popular term "legalization of drugs" is a misleading one. It should be stated at the outset that these proposals in no way envisage the repeal of laws which make the unauthorized use of drugs unlawful, although the designation may so imply. To the contrary, they are based on existing laws currently in effect and do not contemplate their amendment. Their impact lies in the interpretation and enforcement of present laws which they recommend.

Three principal arguments are offered in support of the legalized drug proposals: (1) The uniform narcotics laws, as they are presently enforced, have failed to eliminate illicit traffic and treat the

diseased addict unjustly. Furthermore, they are the indirect cause of crime because, as interpreted by the Bureau of Narcotics, they prohibit the addict from turning to physicians for treatment, and the latter refuse to treat for fear of prosecution. Thus the addict is compelled to resort to the illicit peddler for his drugs and consequently must rely on criminal acts to enable him to pay the exorbitant prices of the market. (2) The pattern of addiction is so complex that many addicts should be deemed "incurable" and as such should be maintained at their desired level without the necessity of purchasing from the illicit market. Institutional treatment can never "cure" an addict; thus the most comprehensive and well administered commitment program serves no

¹⁸⁷ 28 U.S.C. § 4251 (f) (2) (Supp. 1966).

¹⁸⁸ CAL. WELFARE & INSTITUTIONS CODE §§ 3050-51

permanently useful function, except to keep addicts out of jail.¹⁸⁹ (3) The only way to destroy the illicit market is to destroy the demand for its commodities. An addict who could purchase his drugs at cost would have no reason to turn to underworld suppliers. When the demand dwindled, the market would dry up.¹⁹⁰

A series of Supreme Court decisions followed passage of the Harrison Act of 1914. In *Webb v. United States*,¹⁹¹ the Court affirmed the conviction of a physician who had been indicted for the indiscriminate sale of narcotics. The doctor was clearly not within the exceptions of the Harrison Act¹⁹² but in so holding the Court answered a question¹⁹³ certified to it by the Bureau of Narcotics in such a manner¹⁹⁴ that thereafter

it became possible for the [Bureau] to warn doctors against prescribing drugs to addicts for the purpose of avoiding withdrawal distress or keeping the addicts comfortable.¹⁹⁵

The decision formed the basis for the Bureau Regulation which declares that drugs issued "for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use" are not within the exception to the Harrison Act.¹⁹⁶ However in a later case,¹⁹⁷ the

¹⁸⁹ "Regardless of how many of the 8,000 committed to treatment during the first year are eventually cured, their mere removal from the streets will be important, according to some officials." New York Times, March 27, 1967, p. 26. col. 5.

¹⁹⁰ See generally LINDESMITH, *THE ADDICT AND THE LAW* 243-302 (1965); A.B.A.-A.M.A. JOINT REPORT, *supra* note 150 at 92-108; *Hearings, supra* note 149 at pt. 5, 1310-1413.

¹⁹¹ 249 U.S. 96 (1919).

¹⁹² INT. REV. CODE OF 1954 § 4705 (c) (2).

¹⁹³ The certified question:

If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use is such an order a physicians' prescription under exemption (b) of section (2) . . . ? A.B.A.-A.M.A. JOINT REPORT, *supra* note 150 at 71.

¹⁹⁴ The Court answered:

to call such an order for the use of morphine a physicians prescription would be so plain a perversion of meaning that no discussion is required. *Id.* at 72.

¹⁹⁵ *Ibid.*

¹⁹⁶ di Suvero, *Drug Offenses and the New Penal Law*. 32 BROOKLYN L. REV. 287, n. 52 (1966). Clearly neither the statute nor the regulation precludes a physician from giving an addict a moderate amount of drugs in order to relieve a condition incident to addiction if the physician acts in good faith and in accord with fair medical standards. (Text of the Regulation printed therein.)

¹⁹⁷ *United States v. Linder*, 268 U.S. 5 (1925).

Court commenting on *Webb* stated:

The opinion cannot be accepted as authority for holding that a physician who acts bona fide and according to fair medical standards may never give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction. Enforcement of the tax demanded no such drastic rule, and if the Act had such scope it would certainly encounter grave constitutional difficulties.¹⁹⁸

Thus, a doctor *may* prescribe to an addict, in good faith and guided by proper medical standards, in moderate amounts to relieve conditions incident to addiction.¹⁹⁹ Such is the state of the law today. However, continued threat of prosecution has intimidated the medical profession to abandon treatment of addicts almost entirely.²⁰⁰

The proponents of legalized distribution would extend the principal of the last quoted decision. In effect, any eligible addict would become a "patient" and would regularly be given his drug requirements "in order to relieve conditions incident to addiction." He would be "maintained" either by the state or by a personal physician, his doses would be properly regulated, efforts would be made to improve his health, and he would be urged to voluntarily withdraw from the use of drugs.

In view of the sociological and psychological complexities of drug addiction, some authorities suggest that it be designated an "incurable" disease.²⁰¹ The sociological explanation of addiction discussed above lends support to this suggestion. Under present treatment methods, including commitment, there is no guarantee that the addict will be cured upon release—in the sense that he will not again resort to drug use outside the institution. While doctors can destroy physical dependence with relative ease, it is considerably more difficult to eliminate the sociological factors which play an important role in the process of relapse, and the psychological dependence which environmental pressures often induce. Accordingly, it can be said that the addict will not be cured unless it is certain

¹⁹⁸ *Id.* at 22.

¹⁹⁹ For a comprehensive discussion of the physician cases see generally LINDESMITH, *THE ADDICT AND THE LAW* 5-21 (1965); A.B.A.-A.M.A. JOINT REPORT, *supra* note 150, 68-82 (1961).

²⁰⁰ See generally di Suvero, *supra* note 196 at 300 & n. 64-301 & 65 (1966).

²⁰¹ Howe, Dr. Hubert S., testifying in *Hearings, supra* note 149 at pt. 5, 1355 (1955); King, R., testifying in *Hearings, supra* at 1395.

that he will be able to withstand the opportunity to relapse.

This can be accomplished by removing the addict from the social strata of addiction altogether;²⁰² by supervising him closely, in an advisory capacity, after his release into the old environment;²⁰³ or by trying to eliminate the environment itself. The proposals for legal distribution are directed toward accomplishment of the latter, by destroying the illicit market in drugs. It is argued that only when this element of the addicts' environment is eliminated will their chances of "cure" be significantly improved.

While there are admittedly cases where addicts have been completely rehabilitated and have not returned to the use of drugs after release,²⁰⁴ the statistics on relapse plainly indicate that they are exceptional instances. A genuine cure is effected only when relapse is avoided, as with any disease. Relapse is caused largely by sociological factors—the most significant being the ready availability of drugs in the illicit market. It is suggested that so long as the market continues to flourish, it cannot be said that any addict who is released from an institution is properly cured.

Proposals for the legalization of drug distribution rest on three observations. The first is that addiction is so closely related to sociological factors that institutional programs for mandatory withdrawal accomplish little of lasting importance. The second is that the maintenance of a state of addiction is not particularly harmful—physically or psychologically—if properly administered and carefully regulated. The third observation is that the most harmful aspects of drug addiction are attributable to the illegality of drugs. Unlawfulness gives rise to a black market in drugs, which flourishes in particular segments of society, which in turn urge, give birth to and subsequently nourish the abuse of narcotics. Theoretically, if drugs were

available through personal physicians, clinics or other non-syndicate sources, at prices only a fraction of current costs, addicts would have no cause to deal in the market, and it would dry up. Furthermore they would no longer have to resort to criminality to meet drug costs. Finally, they would no longer be subjected to the possibility of long and unjustifiable imprisonment for acts necessarily attributable to their disease. Ideally, the addict could be induced away from drugs by a physician rather than a policeman.

If the economics of legalization are correct, and if it could be shown that under such a program at least as many addicts would be *permanently* cured of their own volition as are cured under the punitive system, the proposals would seem worthy of careful consideration. Any program promising elimination of the market as well as humane treatment of the addict is appealing. Significantly, this is the only program yet devised which can make such a promise.

There is evidence that programs of mandatory confinement for supervised withdrawal and physical rebuilding, followed by close after-care supervision in the nature of parole, have achieved notable success without maintaining the addict on drugs.²⁰⁵ It is probable that most persons—given a choice between maintenance and non-maintenance programs and assuming comparable chances of success—would look to the latter method.

Legalization proposals have as their most formidable opponent the fact that they appear to be defeatist in nature. Excessive use of drugs has historically been alien to average thinking in this country, and the concept of the state allowing the maintenance of persons on such drugs is even more unorthodox.²⁰⁶

It should be pointed out however, that the concept is not a new one. A number of distribution clinics were established in the years immediately after the passage of the Harrison Act. Their purpose was to provide "incurables" with sufficient narcotics to relieve their suffering, until such time as an effective scientific treatment of addiction

²⁰² This is the principle upon which the Synanon projects operate. The addicts enter and undergo "cold turkey" voluntarily. Thereafter they usually live at the Synanon House, and rarely return to the environment in which they originally became addicted. See generally Sternberg, *Synanon House—A Consideration of Its Implications for American Correction*, 54 J. CRIM. L., C. & P. S. 447 (1963).

²⁰³ This is the basis of proposals for strict after-care programs—which are provided for but not really implemented in the commitment statutes. See generally Vaillant and Rasor, *The Role of Compulsory Supervision in the Treatment of Addiction*, 30 FED. PROB. 53 (June 1966).

²⁰⁴ Stevenson, *You Can Prevent Drug Addiction—and Cure Victims of Habit, Hearings*, *supra* note 154 at pt. 5, App. B, 1848–53 (1955).

²⁰⁵ See generally Vaillant and Rasor, *supra* note 203.

²⁰⁶ Actually, the underlying principle behind both programs is similar. Commitment and aftercare are aimed at getting the addict off drugs and inducing him to overcome the factors which ordinarily lead to relapse upon release. The significance of environmental factors is certainly recognized. Maintenance proposals are also directed at the environmental factor in the sense that their primary objective is to destroy the drug-inducing environment. Both programs would accomplish the same end, but by different means.

should be discovered. They were operated on the assumption that it was wiser to supply an addict and teach him to maintain physical efficiency under the influence of drugs, than to force him to undergo the physical and mental misery of withdrawal.²⁰⁷

The clinics were closed down rather promptly. Their effectiveness has been the subject of much dispute. H. J. Anslinger, the ex-Commissioner of the Narcotics Bureau, criticized them for attracting new addicts and permitting increased use among those already addicted.²⁰⁸ M. W. Swords, the physician in charge of the New Orleans dispensary, did not deny these charges. He pointed out, however, that many addicts were enabled to live relatively normal lives as a result of the dispensary and that, more importantly, "peddlers in the city were forced to move away . . . as there was no profit possible".²⁰⁹

Whatever the effectiveness of the dispensaries, two things were clear: many of their defects were attributable to administrative inefficiency; and they were not given a fair trial.²¹⁰

The British System

In Great Britain, addiction is treated as a disease and physicians are permitted to maintain addicts on drugs in the course of a doctor-patient relationship. The Dangerous Drugs Act is similar to the Harrison Act. Its function is primarily to license persons authorized to prescribe dangerous drugs, and to require registration of all supplies obtained and distributed by such persons.²¹¹ The act is primarily regulatory, and makes no reference to addiction as such. Under it, doctors and dentists are authorized to possess and supply dangerous drugs "so far as may be necessary for the practice of [their] profession."²¹² The act does not state what is regarded as proper medical practice with respect to addicts, but "the guiding principle in this regard continues to be that established by the Rolleston Committee"²¹³ which provides in part:

²⁰⁷ Swords, *A Resume of Facts and Deductions Obtained By the Operation of a Narcotic Dispensary, Hearings*,—*supra* note 149 at pt. 5, 1730-33.

²⁰⁸ LINDESMITH, *supra* note 199 at 149-51.

²⁰⁹ Swords, *Hearings*, *supra* note 149 at 1736.

²¹⁰ A.B.A.-A.M.A. JOINT REPORT, *supra* note 150 at 101; see generally authorities cited in note 190, *supra*.

²¹¹ SCHUR, NARCOTIC ADDICTION IN BRITAIN AND AMERICA 71-75 (1962).

²¹² *Id.* at 75.

²¹³ *Id.* at 76. The Rolleston Committee was a special medical board appointed by the Government in 1924 to investigate the effects of the new Dangerous Drug Act on the doctor-patient relationship.

morphine or heroin may properly be administered to addicts . . . (b) where it has been demonstrated, after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced, (c) where . . . the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.²¹⁴

Accordingly, under the auspices of provision (c), physicians need not fear prosecution for maintaining an addict on a regular supply of drugs.

The Rolleston interpretation has been called "the crux of the difference between the British system and ours."²¹⁵ As noted above, the federal case law provides that "a physician who acts bona fide and according to fair medical standards may . . . give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction."²¹⁶ The Bureau of Narcotics has continued to threaten physicians with prosecution however,²¹⁷ and addicts in this country have thus turned to the syndicate peddler for their supply. Although the technical state of the law in the two countries is similar, the U.S. statutes have been interpreted by enforcement agencies to prohibit legal maintenance, while the British statutes have been interpreted to permit it. The British addict *must* confide in a physician to get drugs. The doctor has a professional obligation to attempt to cure his patient, but provisions for mandatory cure are non-existent. Basically stated the British approach is "absurdly simple and almost impossible to understand."²¹⁸

The most notable aspect of the British addiction pattern is its lack of an organized black market in opiates, attributed by many to the fact that the drugs are available through legal sources. Legal availability is also said to indirectly account for the fact that there are relatively few addicts in Great Britain. The suggestion finds support in the sociological argument that where the illicit market does not exist or is destroyed, an "addiction substratum" conducive to drug abuse does not arise.

The effectiveness of the British system is cur-

²¹⁴ UNITED KINGDOM MINISTRY OF HEALTH, DEPARTMENTAL COMMITTEE ON MARIJUANA AND HEROIN ADDICTION, REPORT 19 (1926).

²¹⁵ LINDESMITH, *supra* note 199 at 168.

²¹⁶ *United States v. Linder*, 268 U.S. 5, 22 (1925).

²¹⁷ See di Suvero, *supra* note 196 at 300-01.

²¹⁸ LINDESMITH, *supra* note 199 at 168.

rently under attack. Although the number of reported addicts in that country is relatively small, it has doubled since 1959, although still not exceeding one thousand.²¹⁹ Proposals for change indicate that the increase is attributable to abuse by physicians of their license to handle drugs. Accordingly, the Government is planning to withdraw the right of doctors to prescribe drugs for addicts. Instead the right of prescription will be limited to psychiatrists in hospitals²²⁰—an approach reminiscent of the clinic system mentioned above.

Such an amendment would in no way alter the principle behind British treatment of the problem. Unauthorized use would remain unlawful under the Dangerous Drugs Act, but doctors would still be able to supply addicts with their drug requirements, and there would be no provisions for any sort of mandatory cure.²²¹ The addicts themselves do not and would not have occasion to use drugs without authorization, since they would be forced to confide in psychiatrists who would supply them at nominal costs. Any addict who, for some reason, should choose to deal in the black market would be acting in violation of the Dangerous Drug Act and would be subject to punishment.

The effect of the British interpretation is to coerce addicts into receiving their drug supply from physicians who in turn are professionally bound to treat them and attempt a cure. Concurrently, the illicit market in drugs does not flourish because the demand for high cost drugs obtained at risk of prosecution is virtually non-existent. It is submitted that the recent "increase" in British addiction is attributable to abuse of discretion among physicians. The proposed amendments do not indicate a failure of the permissive approach, nor do they alter the principles or effectiveness of legalized distribution. They merely provide a safeguard against this abuse.

Whether the British approach is medically sound is open to dispute. As indicated above, maintained doses of opiate drugs have a relatively mild effect on the user. Although the system has always been condemned by the Narcotics Bureau, at least one

²¹⁹ The British Minister of Health recently reported that "The total number of dangerous drug addicts known to the Home Office has risen from 454 in 1959 to 927 in 1965," *New York Times*, Jan 31, 1967, p. 16.

²²⁰ *Ibid.*

²²¹ *Ibid.* Apparently the British do not have the aversion to state-maintenance of a state of addiction which prevails in this country. In view of the evidence presented above this would seem the more reasonable attitude.

influential medical association has suggested its adoption.²²²

It is submitted that such a program would be the most suitable method of dealing with the problem of opiate addiction. At the least it offers sufficient promise to warrant a fair and impartial test. Maintenance on drugs might not be medically ideal, but if properly administered and carefully regulated it would certainly be an improvement over the present lot of the criminal addict. Furthermore, the economic aspects of the proposal appear sound. There is no valid evidence to indicate that addicts would be unwilling to frequent the dispensaries. Since drugs would be readily available at a fraction of the current market cost, demand for peddler's goods would necessarily decrease. In turn, the necessity for addicts to turn to crime or sales to support their habit would be abolished. As was seen, addiction is frequently attributable to the drug-saturated environment and to pressure from associates eager to make new recruits—both to share in their criminality and to expand the market. Dispensation would abolish the environment and destroy the incentive. Furthermore, the incident crime rate would decline.

The most significant aspect of the proposals for legal distribution is that they require *neither amendment of the uniform narcotics acts nor enactment of commitment programs for "criminal" addicts*. They are based solely on the principle that enforcement should be consistent with the already existing interpretation which permits distribution and maintenance on a doctor-patient basis. The addict would have no occasion to possess or sell drugs, since his injections would ordinarily be provided by physicians, either individually or through a state-operated clinic. In turn he would have no fear of criminal prosecution under the acts, and severe punishment would be reserved for the non-addict black market dealer. In fact, retention of the acts would be advisable since it would serve the dual function of punishing the peddler and inducing the addict to seek medical treatment. Withdrawal from drugs would have to be voluntary under the inducement and supervision of a doctor. There would be no need for mandatory commitment programs, although voluntary non-drug programs would remain in operation.

The administrative problems posed by the adoption of these proposals are recognized. One of

²²² See generally *Report on Drug Addiction by the New York Academy of Medicine*. BULLETIN OF THE NEW YORK ACADEMY OF MEDICINE 592-607 (Aug. 1955).

the most perplexing is whether distribution would be administered by individual physicians or by clinics staffed with doctors and appropriate personnel. The former has as its chief appeal the widespread availability of doctors throughout the cities, and the personal contact which the addict would receive.²²³ Its main shortcoming, however, would be susceptibility to abuse by the doctors, as evidenced by the recent British experience.

Clinics have the advantage of centralizing treatment, thus combining all phases—physical, psychological and sociological—in one location. Uniformity of treatment and accurate record-keeping would also be facilitated. However, access would be more difficult and there might be a tendency for an addict-society to develop in the areas of the clinics. British proposals seem to compromise this issue by designating hospitals as distribution centers. They are numerous and accessible, but still capable of centralized control. Whether such a choice would be successful in this country, considering the number of addicts involved, is open to question. It is submitted that consideration of this and other proposals, in the light of past failure, could lead to the establishment of a suitable program for distribution which could be carefully regulated yet remain accessible to addicts.

Another question raised by these proposals is whether drugs should be distributed on an "ambulatory" basis, where the addict is given a supply for self-administration at regular intervals, or on an individual injection basis, where the addict must report for each injection. British physicians apparently prescribe or administer as the situation dictates,²²⁴ but the prescription method is probably responsible for the creation of new addicts, since the drugs are easily capable of diversion when un-

necessarily excessive doses are prescribed. The individual injection method is more inconvenient for the addict, but convenience would not be the object of the program. It would seem that the ambulatory system should be avoided, and that addicts would have to report for each dose, which would be regulated to accommodate working hours and similar requirements.

Other administrative problems would doubtless arise. It is proposed, however, that the legal maintenance theory is principally sound and capable of efficient and effective operation. It is the most logical and appealing method yet devised for the elimination of the illicit market in drugs, the crime incident to drug abuse, the physical suffering of withdrawal, and the injustice of the uniform acts as they are now enforced. Furthermore, the legal basis is already established and the system could be effected almost immediately without necessity of special legislation. The only way to determine whether it is a suitable method is to give it a fair and impartial test.

The most imposing obstacle which the establishment of such a program would have to overcome would be public opinion—now firmly embedded in the position that maintenance of a dependance on drugs is an evil to be avoided and supported completely by the Bureau of Narcotics. The odds against overcoming this obstacle, steeped as it is in misinformation, are admittedly great.

In view of such odds, it is necessary to offer *alternative* proposals for consideration based on present interpretations. They necessitate the amendment of uniform narcotics acts and revision of commitment provisions, and are based on the following conclusions about drug abuse and existing law—drawn from the evidence presented thus far.

CONCLUSION

1. Drug addiction is a complex phenomenon. Its elements are physiological, psychological and sociological in nature, with a particular emphasis on the latter. Of the three, the physiological complications appear to be the best understood and the least difficult to overcome. The psychological factors are exceedingly difficult to explain, but their relationship to environment and class structure is evident, hence the em-

phasis on sociological patterns as the basic cause of addiction.

2. A person who is addicted to drugs in the sense that he depends on them physically and emotionally, is suffering from illness. While his decision to use drugs cannot be condoned, his reasons for doing so are not fully understood and appear, in a sense, to be involuntary. As a sick man he cannot be condemned and must be treated accordingly.

3. Drugs are capable of abuse. The opiates do not produce the grave effects often attributed to them, but they are dangerous to the extent

²²³ See generally LINDESMITH, *supra* note 199, at—.

²²⁴ King, *Appendix B. A.B.A.-A.M.A. JOINT COMMITTEE REPORT ON NARCOTIC DRUGS—Drug Addiction: Crime or Disease?* 127 (1961).

that they may cause death if taken in excessive doses, and they produce analgesic and euphoric effects which are not compatible with the normal functioning of the body. More importantly, they are sold in unknown degrees of dilution, thus threatening the addict with overdose. Furthermore, they are closely associated with infection induced by unsterile injection. Accordingly, while the state should not punish a person for suffering the illness of addiction, or for use incident to addiction, it may regulate the overall use of opiate drugs and must regulate the transfer of such drugs.

The so-called "dangerous drugs" are to be distinguished. Many of them appear to have more serious physiological effects, rendering their users either aggressive or totally incapable of self-control. To this extent, strict regulation of their use and sale is required. LSD and comparable hallucinogens appear to be the most dangerous drugs currently in use. They are most susceptible to abuse and produce the most damaging behavior and effects. They have little or no medical value. Their use, possession and sale should be strictly forbidden, except for research purposes.

4. The Uniform Narcotics Laws, as written and enforced, treat the drug addict unjustly. They are largely ineffective against the supplier and dealer in the illicit drug market for whom they were intended. The heart of the drug abuse problem is not the street corner "junkie" or the addict peddler. It is the criminal who sells the drugs *for profit*. The Uniform Narcotics Act and the state legislation modeled after it should be amended to recognize this fact.

5. The new civil commitment statutes are admirable to the extent that they theoretically rectify the above injustices, but questionable to the extent that they do not accomplish this

end. They need revision even as they go into effect.

6. The best treatment for drug addiction is not long confinement, although confinement for some period is recognized as necessary. Physical withdrawal takes a matter of days and nourishment a matter of months. Elimination of emotional disorder, where it really exists, may take longer. The real problem however, is re-adjusting to a drug-filled environment without resorting to the drugs.²²⁵ Such a readjustment cannot be made within the confines of an institution. However, neither can it be made alone. When an addict has been physically withdrawn, nourished and emotionally stabilized, he should be released into the environment in which he will eventually have to function and, under the control and supervision of an authority, learn to live there without reverting to the use of drugs. Since the problem of environment and social adjustment is one of the principal factors of addiction, it is difficult to comprehend the rationale of separating the addict from that environment. It is doubtful that he can be "taught" to avoid relapse when he is released so long as he is in the temptation-free, clinical atmosphere of an institution. The addict should be released as soon as possible under the mandatory supervision of some authority to both induce and compel him to stay off drugs.²²⁶ Except in exceptional cases, there is no *convincing* evidence that an addict should ever be institutionalized for more than two years even when he has been committed for a non-drug crime incident to his addiction. Statutes to the contrary should be amended. Great stress should be placed on the development of after-care programs.

7. Mandatory prison sentences for drug violations should be eliminated. Judicial discretion should be reinstated.

PROPOSALS

I. The uniform acts should be amended to provide:

A. Use

1. The use of opiate drugs (marijuana and dangerous drugs excluded) or their synthetic derivatives for purposes other than the maintenance of a state of addiction should be a misdemeanor punished by _____ term of imprisonment. The trial judge should have sentencing discretion.

2. Determination of whether a state of addiction in fact exists should be made as soon as possible after arrest.

(These provisions would serve to discourage new experimentation in drugs, and would not impose unconstitutional punishment on persons

²²⁵ Brown, *Narcotics and Nalline: Six Years of Testing*, 27 FED. PROB. 27 (June, 1963).

²²⁶ See generally Vaillant and Rasor, *supra* note 203.

suffering from a disease, thereby complying with the *Robinson* decision.)

B. Possession

1. Possession of opiate drugs in amounts not exceeding _____ grains should be a misdemeanor, punishable by imprisonment at the discretion of the trial judge.
2. Possession with the intent to sell for profit not incident to the maintenance of a state of addiction should be a crime punishable by _____ term of imprisonment.
3. Possession for the sole purpose of maintenance of a state of addiction should be a misdemeanor for which the defendant would be committed under provision _____ of the commitment statute.
4. Possession with intent to sell for the sole purpose of supporting a state of addiction should be a misdemeanor for which the defendant would be committed under provision II-A-1 of the Commitment Act.
5. Where it appears that possession with intent to sell is not for the sole purpose of maintaining a state of addiction, the judge should have discretion to commit under II-A-1 for the purposes of treatment, with subsequent imposition of penal sentence upon release. Time served under commitment should be credited to service of sentence.
6. Any person who comes within paragraphs 3, 4 or 5 of this section should be denied commitment under II-A-1 only in the event that the trial judge in the exercise of his discretion shall deem him unfit for commitment.
7. Possession of opiate drugs in an amount exceeding _____ grams should be presumptive evidence of an intent to sell.
8. Determination of a state of addiction should be made as soon as possible after arrest.

C. Sale

1. Transfer, exchange or sale of opiate drugs for purposes of profit not incident to the maintenance of a state of addiction should be unlawful and subject to a term of _____ year's imprisonment. Where the transferee is a minor

punishment should be more severe.

2. Transfer, exchange or sale solely incident to the maintenance of a state of addiction should be a misdemeanor for which the defendant would be committed under provision II-A-1.
3. Paragraphs I-B-5 and I-B-6, providing for judicial discretion should also apply to this section with respect to sales.
4. Again, determination of a state of addiction should be made immediately after arrest.

D. Marijuana

1. Possession or sale of marijuana should be a misdemeanor punishable by fine. Subsequent offenses (after two convictions) should be punishable by a short term of imprisonment.
2. Use should be subject to fine. Subsequent offenses (after two) should be punishable by a short term of imprisonment.

E. Detoxification

1. Provisions should be made for the care, treatment and detoxification under competent supervision of any accused suffering from withdrawal while in custody.

- F. No mandatory minimum sentences should be included in any of these provisions.

II. Commitment statutes should be enacted by every state to upplement the narcotics regulations. They should provide:

A. Drug-related offenses.

1. Any persons convicted under the provisions above, relating to possession or sale for maintenance of addiction (Sections I-B-3,4; I-C-2), or certified for commitment under Section II-C-1 and determined to be addicted to drugs should be committed for treatment for a period not to exceed (one year), with mandatory supervision upon release for a period not to exceed two years. This provision should not be limited by reason of prior commitments under it. Nor should the accused be denied access to commitment by reason of any prior conviction for crime or by reason of prior commitment under these statutes, unless excluded under Sections I-B-5,6 at the discretion of the trial judge.

B. Non-Drug Offenses

1. Upon conviction for any misdemeanor or felony, except drug offenses, where the defendant is found to be addicted, and the court determines that the crime was committed solely for purposes incident to the maintenance of a state of addiction, and that the crime was attributable to the fact of addiction, the defendant should be certified to be committed for treatment until cured, but for a period not to exceed two years.
2. This provision should not be limited by prior conviction of crime. However, if in the judgment of the court the defendant is deemed unfit for the commitment program or if the gravity of the offense is such that in the interests of justice the court decides that punishment should be imposed, the defendant should be certified for treatment for a period not to exceed four months, then bound over to serve a sentence as prescribed under the penal law. Time served under commitment should be credited to the service of sentence.
3. If the court finds that the crime was not incident to or attributable to the state of addiction, the defendant should be certified and sentenced under the procedure of paragraph two.
4. If it is determined that the defendant is not addicted to the use of drugs, these provisions should not apply and he should be sentenced as convicted.

C. Pre-trial Commitment

1. Any person charged with a misdemeanor or a felony, except drug-related offenses and offenses for which the prescribed penalty is death or life imprisonment may, with the permission of the court, petition for certification to be committed. If the accused is found to be addicted to the use of drugs the court may, in the exercise of its discretion, so certify in accordance with the provisions of Section II-A-1.
2. If for any reason certification is denied, the accused should be tried as charged subject, in appropriate cases, to the provisions of Section II-B.

3. Where certification is granted charges will be continued. Upon certification by proper authorities that treatment has been satisfactorily completed, charges should be dismissed. If for any reason such certification is denied, charges should be reinstated and the defendant tried, subject to the provisions of Section II-B. If the defendant is convicted and sentenced, time served under commitment should be credited to the term.

D. After-care Program

1. Upon release from commitment every person should be required to submit to post-commitment supervision in the form of parole for a period not less than two times the maximum allowable commitment. He should be required to report regularly and submit to both regular and surprise Nalline testing.
2. Use of drugs or ——— consecutive failures to report should be "parole" violations subject to punitive sanctions. Anti-narcotic testing should be frequent enough to detect drug violations prior to the re-development of addiction, so that punitive sanctions can be constitutionally imposed.

III. Dangerous Drugs

1. The states should adopt legislation modeled after a Uniform Dangerous Drug law. Regulation of these drugs should be approached differently because they are so widely distributed for legitimate medical purposes. It should be directed at the prevention of diversions from the legal chain of distribution.²²⁷
 - A. Dangerous drugs should include all amphetamines, barbiturates and similar derivatives capable of producing either a stimulant or depressant effect on the central nervous system.
 - B. Import, manufacture and distribution of dangerous drugs should be limited to properly registered and licensed persons, including manufacturers, physicians and pharmacists.

²²⁷ Many of the following proposals are based on the recently enacted Drug Abuse Control Amendments of 1965, 21 U.S.C. 321-360(a) (1966).

- C. All persons so registered and licensed should be required to keep strict records of manufacture, inventories, receipts and disbursements of any dangerous drug.
- D. Import, manufacture, distribution, sale or possession of any dangerous drug, other than for personal use, or in an amount exceeding _____ (quantity above which a presumption of other than personal use would arise), without proper registration and licensing, should be subject to fine and/or imprisonment for subsequent offenses.
- E. Failure to keep proper records of manufacture, receipts and disbursements should be subject to fine with imprisonment for subsequent offenses. A Drug Bureau should be established for the purpose of regular record inspection.
- F. Possession for personal use should be excepted from the provisions of the statute. The problems of proof which would accompany a charge of "illegitimate" use of dangerous drugs would be impossible to overcome, in light of the fact that the drugs are often of medical value. Regulation must be accomplished through strict enforcement of provisions governing distribution, rather than by prosecution of abusers.
- G. The operation of any motor vehicle on a public way while knowingly under the influence of a dangerous drug should be punished by a severe fine and/or a term of imprisonment, even where the influence is attributable to a state of addiction to such drugs.
- H. Any person charged with or convicted of any crime the punishment for which is not death or life imprisonment, and found to be addicted to any dangerous drug, should be treated as under the provisions for opiate addicts, at the discretion of the court, so long as the crime is shown to be attributable to the addiction. This provision should apply to sale and possession offenses as well.
- I. Maximum allowable penalties should

be severe, but in no case should minimum mandatory penalties be imposed. There should be provisions for judicial discretion in every instance.

IV. Hallucinogenic Drugs²²⁸

- 1. Import, manufacture, distribution or sale of LSD, STP or any other drug capable of producing a hallucinogenic effect upon its user should be strictly prohibited, except where authorized for scientific purposes. Penalties for violation should be severe, including fine and/or imprisonment.
- 2. The use of hallucinogenic drugs should be prohibited. Persons convicted of use should be subject to fine for a first offense, and fine and/or imprisonment for subsequent offenses.
- 3. The operation of any motor vehicle while knowingly under the influence of a hallucinogenic drug should be subject to fine and/or imprisonment.
- 4. In no case should minimum sentences be made mandatory, and judicial discretion should be provided for in every instance.

Since the hallucinogenic drugs serve no legitimate medical function, are not addictive in any sense, are not incident to a disease, and are capable of producing unusually harmful effects, they require maximum prohibition. Accordingly, "use" may, and should be, subject to penalty. The argument that total prohibition will produce an illicit market must be taken into account, but it is open to question. The users of hallucinogens are members of a society different from that of the opiate user. The sociological and psychological factors leading to use of the respective drugs are obviously dissimilar. It is doubtful that the "intellectual" drug user who takes drugs in search of reality rather than to suppress it, will be willing to pay the black market price and run the risk of a stiff fine or long imprisonment just to attain a more stimulating "experience." There is no evidence that such persons are either physically or emotionally dependent on the drugs, as are opiate addicts. The requisite necessity is non-existent. It is submitted that

²²⁸ See, e.g., NEW YORK MENTAL HYGIENE LAW § 429 (Supp. 1967); The Drug Control Amendments, *supra* note 227, also include provisions regulating hallucinogenic drugs.