The Catholic Lawyer

Volume 8
Number 4 *Volume 8, Autumn 1962, Number 4*

Article 9

Note: Criminal Law and the Problems of Drug Addiction

Follow this and additional works at: https://scholarship.law.stjohns.edu/tcl

Part of the Criminal Law Commons

This Notes and Comments is brought to you for free and open access by the Journals at St. John's Law Scholarship Repository. It has been accepted for inclusion in The Catholic Lawyer by an authorized editor of St. John's Law Scholarship Repository. For more information, please contact selbyc@stjohns.edu.

NOTES AND COMMENTS

NOTE: CRIMINAL LAW AND THE PROBLEMS OF DRUG ADDICTION

Although there are no definite statistics, the number of narcotics addicts in the United States has been estimated to be in the area of sixty thousand.[1] *Approximately thirteen per cent of that number are below twenty-one years of age.*[2] *Furthermore, our total exceeds the combined addict population of all other Western nations.*[3] *It has been stated that the criminal activities of these narcotics addicts cost the public more than three hundred million dollars a year*[4] *and that they are responsible for approximately fifty per cent of all crimes committed in large metropolitan areas.*[5] *This menace has not abated in recent years, rather the illicit drug traffic has tripled since World War II.*[6] *These statistics are shocking and when considered in conjunction with the fact that there seems to be no effective cure for drug addiction,*[7] *their significance reaches alarming proportions.*

Narcotics in General

Narcotic is a term of convenience used to designate the natural drugs, opium, cocaine, marijuana, their derivatives and the many synthetic compounds which produce similar physiological results. Probably ninety-five per cent of American addicts use heroin.[8] Properly used for medical purposes, the narcotic drugs are a great boon to mankind, but their misuse has created a menace to society. Depending upon the individual, the first encounter with any of the drugs is likely to be pleasurable. The feeling referred to as euphoria or nirvana is anologous to exaltation, daydreaming or a state of complete peace. However the mere use of a narcotic drug, by itself, is not addiction.[9]

There are a great many definitions of addiction, but the one most widely accepted has been put forth by the World

[1] SENATE COMM. ON THE JUDICIARY, *Illicit Narcotics Traffic,* S. REP. No. 1440, 84th Cong., 2d Sess. 2 (1956).

[2] *Ibid.*

[3] *Ibid.* This holds true "if the reports of other nations to the United Nations Commission on Narcotics are correct. . . ." *Ibid.*

[4] 1959 N. Y. LEG. DOC. No. 7, REPORT OF JOINT LEGISLATIVE COMMITTEE ON NARCOTICS STUDY 122.

[5] COMM. ON THE JUDICIARY, *supra* note 1, at 2.

[6] *Ibid.*

[7] See LINDESMITH, OPIATE ADDICTION 49-50 (1947).

[8] Comment, *Narcotic Regulation,* 62 YALE L. J. 751, 752 (1953).

[9] THE JOINT COMM. OF THE A.B.A. AND THE A.M.A., REPORT ON NARCOTIC DRUGS 25 (1961). "There are many persons, particularly in the slum areas of our large cities who have the drug habit —who use drugs more or less regularly, but who have not become addicted." *Ibid.*

Health Organization of the United Nations: "Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug. . . ."[10] Another authority has broken the characteristics of addiction down to (1) *tolerance,* which is the need to keep increasing the dose as the drug is taken frequently over a long time span; (2) *habituation,* which is the personality's emotional and psychological reliance on the drug in place of the more usual kinds of satisfactions; (3) *physical reliance* which is the body's need to continue the drug in order to avoid the severe effects of the withdrawal syndrome.[11] Use of drugs temporarily helps to establish self-confidence, quells disturbing aggressiveness, and depresses the primary drives of hunger, thirst, fear of pain and sexual urge.[12] Although the characteristic maladies of withdrawal generally disappear within three or four days, the memory of the experience with narcotics persists long after the consumption of the drug has been stopped and the patient has been restored to health and acts as a predisposing factor toward relapse.

The Narcotic Addict

It is contended that no economic or social class is immune to addiction.[13] However, there is definite agreement that the great majority of narcotic addicts suffer from emotional or character disorders which predispose them to addiction.[14] The addict-prone person who falls prey to narcotics would probably require psychiatric help, even if he did not resort to the use of drugs. In persons with stable personalities, social pressure, conscience and well balanced psychological make-up negate the pleasurable effects produced by drugs sufficiently to prevent their continued use. The socioeconomic factors of family disorganization, minority discrimination and slum conditions are inherent in the personality disturbances which cause an individual once exposed to narcotics to become an addict.

Whether it is because the typical drug addict is immature or because having been physically cured, he must nevertheless return to the same environment which spawned his illness, the relapse rate among addicts is phenominally high.[15] In a study made of "cured" adolescent drug users in New York it was found that more than ninety-six per cent became reinvolved in activities that customarily would expose them anew to criminal prosecution or to hospital confinement.[16]

---

[10] U.N. EXPERT COMM. ON DRUGS LIABLE TO PRODUCE ADDICTION, REPORT 6, 7 (W.H.O. Technical Report Series No. 21 1950) in Winick, *Narcotics Addiction and its Treatment,* 22 LAW & CONTEMP. PROB. 9, 10 (1957).

[11] Winick, *Narcotics Addiction and its Treatment,* 22 LAW & CONTEMP. PROB. 9, 10 (1957). The withdrawal syndrome referred to is a painful illness caused by the failure to satisfy the new biological need created by the repeated administration of the drug. Its effects include yawning, sleeplessness, vomiting, diarrhea, sweating, sneezing, running nose, fever, aches, and involuntary movement of muscles. *Ibid.*

[12] COUNCIL ON MENTAL HEALTH OF THE A.M.A., REPORT ON NARCOTICS ADDICTION 22 (Reprinted from 165 J. of A.M.A. 1957).

[13] DEUTSCH, WHAT WE CAN DO ABOUT THE DRUG MENACE 12 (Public Affairs Pamphlet No. 186, 1952).

[14] *Ibid.;* THE JOINT COMM. OF THE A.B.A. AND THE A.M.A., *op. cit. supra* note 9, at 51.

[15] THE JOINT COMM. OF THE A.B.A. AND THE A.M.A., *op. cit. supra* note 9, at 90-91.

[16] See ELDRIDGE, NARCOTICS AND THE LAW 95 (1962).

Successful treatment of the person with a history of drug addiction is a very slow, gradual and expensive process taking over a long period of intensive psychiatric and rehabilitative care. However, the greatest challenge to the patient comes after he has been released from an institution. The public attitude has generally been that an addict is a depraved fiend who commits heinous crimes. This has made it difficult for the reformed addict to adjust to a normal life, establish intimate social relationship, secure employment and maintain his self image. If he is not accepted, he will return to his former associates who will once again exploit his disturbed personality. Today it is universally accepted that drug addiction is a disease, not because of the painful physical effect of withdrawal on an addict, but because of the various psychic phenomena involved. Despite the importance of the problem and the considerable writing in the area, there are many misconceptions and contradictatory theories surrounding this illness. A majority of the authorities maintain that the use of such drugs as heroin or morphine is consistent with the maintenance of both a reasonable state of health and a reasonable degree of efficiency on the part of the indidividual user.[17] The ill effects which many addicts display are not caused by the drug itself but rather by the lack of the drug, the constant preoccupation with obtaining the drug and the legal status of a drug user.[18] Yet a drug addict may fear establishing a relationship with a physican, for addicts technically are criminals[19] and state laws generally require a doctor who treats an addict to report that fact to the state narcotic bureau. Although it is universally accepted that drug addicts indulge in a wide variety of predatory crime to produce money with which to support their addiction, there is still disagreement as to whether the criminal activity precedes the addiction. Most authorities are of the opinion that the rate of prior criminal involvement is between twenty-five per cent and fifty per cent depending on the groups of addicts studied.[20] This is not a high rate of illegal activity when consideration is given to the fact that the groups from which the addict is drawn does not have the same respect for property, educational achievement or sexual control as does the middle-class segment of American society. Contrary to the public conception, the crimes in which an addict will engage are generally against property (theft, shop lifting and pickpocketing) rather than against the person (rape, murder and assault).[21] The drug appears to reduce both the inclination to violent crime and the capacity to engage in sophisticated types of criminal action requiring much planning. Addiction has the spreading character of a contagious social disease. Most addicts are not initiated into

[17] See, *e.g.*, COUNCIL ON MENTAL HEALTH OF THE A.M.A., *supra* note 12, at 47; THE JOINT COMM. OF THE A.B.A. AND THE A.M.A., *op. cit. supra* note 9, at 46-49. *Contra,* U.S. BUREAU OF NARCOTICS, TREASURY DEP'T, LIVING DEATH 1-3 (1956).

[18] THE JOINT COMM. OF THE A.B.A. AND THE A.M.A., *supra* note 9, at 48-49.

[19] In order to be an addict a person must possess narcotics and Section 2 of the Uniform Narcotic Drug Law makes possession by an unauthorized individual a crime. 9B UNIFORM LAWS ANN. 279, 285.

[20] See, *e.g.*, Ausubel, Controversial Issues in the Management of Drug Addiction: Legalization, Ambulatory Treatment and the British System 3 (Paper read at the convention of the Am. Psychological Ass'n, Sept. 4, 1959); DEUTSCH, *supra* note 13, at 12.

[21] COUNCIL ON MENTAL HEALTH OF THE A.M.A., *supra* note 12, at 24-26.

the habit by a narcotic peddler nor by the deliberate efforts of another addict.[22] The spread is a casual one stemming from imitation and the general social relations within the cultural group from which most addicts come.

The Narcotic Addict and Society

Granting the existence of a narcotic addiction problem, the experts have not been able to reach agreement on what to do with the addict. It is felt, on the one hand, that true narcotic addiction per se is a sickness or medical condition in need of treatment upon which punishment has no effect and that therefore the present legal status of addiction as a crime is an unfortunate social anachronism. On the other hand, it is pointed out that the primary purpose of criminal law is the safety of society and that the potentially ruinous consequences of large scale addiction are so great that control of the problem cannot be left to the discretion of the medical profession. Despite the furor created by proponents of the former view, the federal government has maintained its basic position for almost fifty years.

Federal Legislation

By 1914, the use of opium in the United States had increased to such a degree that, if not dealt with immediately, it would have precipitated widespread social destruction. State and municipal laws were totally ineffective as the rate of use of opiates grew to proportions which dwarfed the present usage ratios.[23] At that point Congress intervened and passed the Harrison Act.[24] This law, based on the federal taxing power, provided for a nominal excise tax on all drugs,[25] required all persons who handled drugs to register with the Treasury Department,[26] and made it unlawful to transfer drugs in any manner except pursuant to a written order prepared on Treasury Department forms.[27] A like restraint is placed on the transfer of marijuana, but the tax rate in the provision is prohibitive.[28] These acts are further supported by the Narcotic Importation Act[29] which prohibits entry of all opiates, except for such quantity as the Secretary of the Treasury deems necessary to satisfy national medical and scientific needs and expressly forbids the importation of any raw opium for the manufacture of heroin. After extensive hearings in 1951 and 1956, the federal government drastically increased the penalties for offenses under the Importation, Harrison and Marijuana Tax Acts.[30]

The federal laws allow doctors to distribute narcotics only "for legitimate medical purposes" and only "in the course of his professional practice. . . ."[31] Many physicians feel that the phrases "legitimate medical purposes" and "professional practice," mean that they are entitled to regard addiction as a disease and the addict as a

[22] Chein & Rosenfeld, *Juvenile Narcotics Use*, 22 LAW & CONTEMP. PROB. 52, 58 (1957); ELDRIDGE, *op. cit. supra* note 16, at 28-29.

[23] See Ausubel, *supra* note 20, at 8.

[24] INT. REV. CODE of 1954, §§ 4701-36.

[25] INT. REV. CODE of 1954, § 4701.

[26] INT. REV. CODE of 1954, §§ 4721-22.

[27] INT. REV. CODE of 1954, § 4705.

[28] INT. REV. CODE of 1954, §§ 4741-76.

[29] 35 Stat. 614 (1909), as amended 38 Stat. 275 (1914); 42 Stat. 596 (1922); 43 Stat. 657 (1924); 46 Stat. 586 (1930); 55 Stat. 584 (1941); 60 Stat. 39 (1946); 67 Stat. 506 (1953), 21 U.S.C. §§ 171-85 (1958).

[30] The Boggs Act, 65 Stat. 767 (1951), 21 U.S.C. 174 (1958). *Cf.* 68A Stat. 860, 26 U.S.C. § 7237 (Supp. III, 1956).

[31] INT. REV. CODE of 1954, § 4704(b)(2).

patient to whom they can prescribe drugs to alleviate the distress of withdrawal. However, the courts, under pressure from the Treasury Department, have waivered in their interpretation of the Harrison Act. In *Webb v. United States*[32] and then in *Jin Fuey Moy v. United States,*[33] the Supreme Court held that where a doctor issues narcotics to an habitual user, not in the course of an attempted cure of the habit, but for the purpose of providing the user with drugs sufficient to keep him comfortable by maintaining his customary use, such is not in the course of "professional practice." A more severely limiting decision was handed down by the Court in *United States v. Behrman,*[34] where it was decided that the prescribing of a drug to an addict was a crime regardless of the physician's intent in the matter. It appeared that these cases were modified by *Linder v. United States.*[35] The Court there explained that addicts

> are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them in the ordinary course and in *good faith,* four small tablets of morphine or cocaine *for relief of conditions incident to addiction.*[36]

However, in spite of the *Linder* case, the Treasury Department has sought and received convictions on the basis of the *Webb* rationale, *i.e.,* good faith treatment in the course of a *cure* is the only legitimate excuse for a physician to distribute narcotics to an addict.[37] Thus, a great many doctors are reluctant to treat drug addicts in the course of their professional practice because his good faith and adherance to medical standards can be determined only after a trial, in which he may lose his reputation, his practice ,and his freedom.

The federal government maintains at Lexington, Kentucky the world's major center exclusively devoted to the study and treatment of addiction. A second smaller federal institution for treatment of male narcotic addicts is maintained at Fort Worth, Texas. Both hospitals admit addicts under sentence by federal courts, those placed on probation as narcotic-law violators provided they submit to hospital treatment and also addicts who apply for admission voluntarily.[38]

New York Legislation

Almost all of the states have followed the federal interpretation of the standards involved in an addict-physician relationship. The New York rule,[39] which is typical of those of other states, allows a doctor to treat drug addicts, providing such addicts are under his control. This has been interpreted to mean that the narcotic addict must be under confinement and that the distribution of narcotics by a doctor on an ambulatory basis is not considered treatment under control and is, therefore,

---

[32] 249 U.S. 96 (1919).

[33] 254 U.S. 189 (1920).

[34] 258 U.S. 280 (1922).

[35] 268 U.S. 5 (1925).

[36] *Id.* at 18 (emphasis added).

[37] Mc Bride v United States, 225 F.2d 249 (5th Cir. 1955), *cert. denied,* 350 U.S. 934 (1956); United States v Brandenburg, 155 F.2d 110 (3d Cir. 1946), *rev'd on other grounds,* 162 F.2d 980 (3d Cir.), *cert. denied,* 322 U.S. 796 (1947).

[38] DEUTSCH, WHAT WE CAN DO ABOUT THE DRUG MENACE 24 (Public Affairs Pamphlet No. 186, 1952).

[39] N.Y. PUB. HEALTH LAW § 3330.

unlawful.[40] Yet until recently, facilities available on a state level for the treatment of narcotic addiction were almost nonexistent. Until 1959, New York, although considered a progressive state, and having over forty-six per cent of the nation's addicts,[41] had no facilities to treat an adult addict.

In the last three years, New York has embarked on a bold program to ease the problems of the drug addict and the problems created for it by the drug addict. When the New York City Department of Hospitals accepted responsibility for addicts who committed themselves voluntarily, it joined Chicago, Detroit and Los Angeles in being the only cities in the nation which provide space for addicts in their hospitals.[42] The State Department of Mental Hygiene now operates a Narcotic Addiction Study and Treatment Center at Manhattan State Hospital, and plans are being made for its expansion. As part of the same program, the State Department of Correction will have its parole officers treat prison inmates who were addicted before they were sentenced, in order to prepare the inmates for restoration to society in a productive capacity. New York City, with the financial assistance of the state, has created a unique establishment—a municipal hospital especially planned for teenage addicts. In 1952, only 197 patients were treated at Riverside Hospital, whereas, in 1957 over 800 were treated.[43] Although it has been shown that the recidivist rate of patients at Riverside is an unfortunate ninety-six per cent,[44] consideration must be given to the fact that the hospital is working with immature youths and therefore the addiction problem is aggravated by the normal problems of adolescence. The fact that twenty-four per cent abstained for a period of six months is considered a significant step toward eventual recovery.[45]

In April, 1962, the New York State Legislature passed the Metcalf-Volker Act,[46] which provides that addicts may be treated as sick people rather than as criminals. Sections 211 and 212 of the act provide that, if arrested for a narcotics or other non-capital offense and proven to be an addict, the individual may choose between mandatory civil commitment with aftercare supervision or a term in prison. If he successfully completes the medically-supervised inpatient and aftercare program,[47] the criminal charges against him will abate.[48] The Commissioner of Mental

---

[40] Bellizzi, *The Legal Aspects of Narcotics Control In New York State*, 37 HEALTH NEWS 4, 5-6 (1960).

[41] U.S. BUREAU OF NARCOTICS, TREASURY DEP'T, REPORT ON TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1961 19 (1962).

[42] 1959 N.Y. LEG. DOC. NO. 7, REPORT OF JOINT LEGISLATIVE COMMITTEE ON NARCOTIC STUDY 36, 44-45.

[43] *Id.* at 52.

[44] ELDRIDGE, NARCOTICS AND THE LAW 95 (1962).

[45] *Id.* at 95-96.

[46] N.Y. MENTAL HYGIENE LAW art. 9 (Supp. 1962). "This portion of the Act dealing with the arrested addict is designed to provide a quick, fair and effective means of moving those arrested addicts who seek their own salvation and whose prime affront to society is their own addiction . . . ." N.Y. MENTAL HYGIENE LAW § 200 (Supp. 1962).

[47] N.Y. MENTAL HYGIENE LAW §§ 211, 212 (Supp. 1962). The aftercare treatment may take the form of home visits by investigators, periodic medical examinations and reasonable regulations pertaining to conduct. *Ibid.*

[48] *Ibid.* However, if at any time the rules are violated or the patient returns to his habit he may be recommitted or sent back to the court as being unresponsive to medical treatment.

Hygiene must be agreeable to accept such addict from the court and his decision is to be based on the individual's ability to benefit from the treatment and the availability of facilities. The court may also use its discretion in deciding who may receive treatment, but certain individual addicts, because of their prior criminal record or other reasons set forth in the sections, are barred from civil commitment.

The Uniform Narcotic Act

Although the federal government has provided a complex regulatory and criminal system to check the growth of narcotic addiction, the actual burden of stemming the tide, in the battle with the criminal element who prosper from the misery of the addict, falls on the individual states. Under the exercise of their police power, the states can regulate the manufacture, distribution, sale and possession of narcotic drugs in the interest of public health and welfare.[49] It appears that forty-nine jurisdictions[50] have adopted the Uniform Narcotic Drug Act[51] or substantially similar legislation. The act explicitly defines who may possess, sell, prescribe or manufacture narcotics and under what conditions. Its provisions clearly outlaw every contact with narcotics, except those expressly permitted by the act. No penalties are prescribed because it was realized that since the incidence of addiction varies greatly from state to state, each state legislature should be free to impose whatever sanctions it sees fit. The degrees and variations each state has placed on the offenses created by the Uniform Narcotic Drug Act have permitted certain states to experiment with new ideas in an effort to create more enlightened treatment procedures for addicts. Possession, except under specified conditions, is uniformly prohibited. However, the rule has been elaborated upon by some states, as in New York, where the quantity of illegally possessed narcotics determines the charge and the punishment.[52]

Addiction As A Crime

Only four states, California,[53] Illinois,[54] Michigan[55] and New Jersey,[56] have statutes which make addiction itself a crime. The statutes generally provide for a jail sentence and then a long period of probation, during which time the court can supervise the activities of the "detoxified" individual and insure that he does not slip back into his habit. The reasons put forth in favor of such statutes include: that society is protected from the activities in which most addicts engage; the addict is taken off the streets where he spreads his disease; the addict is in a position where he will volunteer for treatment; and people are deterred from becoming addicts because of the pe-

[49] Whipple v. Martinson, 256 U.S. 41, 45 (1921).

[50] 9B UNIFORM LAWS ANN. 55 (Supp. 1961).

[51] 9B UNIFORM LAWS ANN. 279 (Supp. 1961).

[52] Possession of large amounts of drugs creates a rebuttable presumption of intent to sell and the crime is a felony with the same punishment as that for sale. N.Y. PEN. LAW § 1751(2) (Supp. 1962). Possession of moderate amounts of narcotics is also a felony but without the presumption and its correspondingly long sentence. N.Y. PEN. LAW § 1751(3) (Supp. 1962). Possession of amounts less than those required for a felony is a misdemeanor punishable by a short jail sentence. N.Y. PEN. LAW § 1751-a (Supp. 1962). These statutes are part of an attempt to reach the peddler and at the same time avoid gathering the addict in the same net.

[53] CAL. HEALTH & SAFETY CODE § 11721.

[54] ILL. ANN. STAT. ch. 38, §§ 22-3 (Smith-Hurd Supp. 1961).

[55] MICH. STAT. ANN. § 18.1124 (1957).

[56] N.J. STAT. ANN. § 2A: 170-8 (Supp. 1961).

riod of confinement required. The underlying purpose of these statutes and the only purpose which could not be as well served by civil commitment, is that when facing a jail sentence, the addict will more readily turn informer and aid the police. However, serious objections to statutes which imprison individuals merely because they are drug addicts were brought to light in *Robinson v. California,*[57] where the Supreme Court judged the California law unconstitutional. Mr. Justice Stewart, writing for the majority, reasoned that although states could establish a program of compulsory treatment for addiction and impose penal sanctions for failure to comply with such a program, they could not put a sick man, *i.e.,* the addicts in jail when he did not use or possess any drugs within the state nor had been guilty of any antisocial behavior. After equating addiction with mental disease, venerial disease and leprosy, the Court concluded that a state cannot imprison a person who might have contracted his illness innocently or involuntarily. In a concurring opinion, Mr. Justice Douglas stressed that diseased people must be treated as patients, as is done in Great Britain, and not as criminals as the California statute provided. In summarizing his position, the Justice declared that "a punishment out of all proportion to the offense may bring it within the ban against 'cruel and unusual punishments' . . . and prosecution for addiction, with its resulting stigma and irreparable damage to the good name of the accused, cannot be justified as a means of protecting society, where a civil commitment would do as well."[58] In his dissent, Mr. Justice Clark put forth a two-pronged argument; the first part defending California's comprehensive and enlightened program for treating addicts and the second part criticizing the majority opinion for its arbitrariness in deciding that hospitalization is the only valid treatment for narcotics addiction. The California legislative program has at its base the concept that addicts are sick people, but a characteristic peculiar to their disease is that they must habitually engage in enormous amounts of crime.[59] The statute in question, Section 11721 of the Health and Safety Code, was aimed at the addict who uses drugs habitually but who has not acted without volition or lost the power of self control.[60] Where the narcotic addiction has progressed past the incipient, volitional stage, California provides for commitment at a state hospital.[61] The overriding purpose of section 11721 was to cure the less severely addicted person by preventing further use and providing for a period of careful supervision, whereas the purpose of civil commitment is to cure the addict who can no longer control himself by extensive medical and psychiatric treatment. The second phase of Mr. Justice

[57] 370 U.S. 660 (1962).

[58] Robinson v. California, 370 U.S. 660, 676-77 (1962).

[59] It is reported that addicts are responsible for 50% of all crime committed in the large cities and 25% of all crime reported in the nation. SENATE COMM. ON THE JUDICIARY, *Illicit Narcotics Traffic,* S. REP. No. 1440, 84th Cong., 2d Sess. 2 (1956). It is estimated that 75% of all shoplifting in Los Angeles is the work of addicts. *The Narcotic Problem,* 1 U.C.L.A.L. REV. 405, 451 (1953).

[60] The section states "no person shall use, or be under the influence of, or be addicted to the use of narcotics. . . ." CAL. HEALTH & SAFETY CODE § 11721.

[61] CAL. WELFARE & INST'NS CODE § 5355. Under this statute an addict is "any person who habitually takes or otherwise uses to the extent of having lost the power of self-control any opium, morphine, cocaine, or other drug. . . ." CAL. WELFARE & INST'NS CODE § 5350.

Clark's opinion contends that the safety of society must be paramount in the administration of justice and therefore the state courts should be able to determine whether or not an addict is a potential menace. The dissent concludes that it is not for the Supreme Court to deny the legislative and judicial judgment of the state of California that the volitional narcotic addiction poses a threat of crime and moral destruction.

The decision rendered in *Robinson v. California*[62] has implications which, if realized, may force the revision of many of our laws dealing with narcotic addiction. It may be reasoned that if a state may not imprison a person who uses drugs because such addiction is an illness and may only be handled civilly, then an addict who commits a crime incident to his addiction may not be responsible for such a crime and the state's only remedy is to submit him to compulsory commitment for cure. This follows logically from the Court's use of the analogy between addiction and insanity, for the insane person is not held responsible for crimes he commits. Critics of present law enforcement policies contend that the placing of penal sanctions on addicts and non-addict distributors alike for their relationship with narcotics has resulted in the pauperization and demoralization of the addicts and the stimulation of crime. Most addicts, it is claimed, only turn to crime because of the high cost of the illicit drug. The reformers also declare that while the safety of society is not insured by putting these sick people in prison and then loosing them to resume their criminal activities and the breeding of their habit, the illegal status of drug addiction increases its attractiveness for antisocial psychopaths and aggressively minded adolescents. They conclude that, as with all social diseases, society's most effective protection against epidemic spread is to locate the infected person and give him curative treatment. However, they point out that since our present approach is penally oriented, our treatment facilities are highly inadequate. The Public Health Service hospitals at Lexington and Fort Worth are understaffed and overburdened with prospective patients.[63] The federal hospitals, as of now, have no effective follow-up facilities nor are they able to force the patients who enter the institutions voluntarily to remain until an objective appraisal of their condition can be made.[64] On a local level, it is noted, no community in the entire nation has an integrated program of hospitalization, psychiatric treatment and rehabilitation for narcotic addicts.[65]

Proposed Solutions

a. *The Clinic System*

Although most authorities agree that our present system of handling the narcotic problem has certain faults, there is no general agreement on any alternative solution. The New York Academy of Medicine formulated an elaborate and widely discussed plan which calls for the establishment throughout the nation of narcotic clinics.[66] The clinics would be attached to general

[62] 370 U.S. 660 (1962).

[63] Winick, *Narcotics Addiction and its Treatment,* 22 LAW & CONTEMP. PROB. 9, 26 (1957).

[64] *Ibid.*

[65] *Ibid.*

[66] New York Academy of Medicine, *Report on Drug Addiction,* 31 BULL. N.Y. ACAD. MED. 592-607 (1955), reprinted in *Hearing Before Senate Committee on the Judiciary Studying Illicit Narcotic Traffic,* 84th Cong., 2d Sess., pt. 5, at 1689-1704 (1956).

hospitals and these could be open twenty-four hours a day, seven days a week. Safeguards would be taken to prevent addicts from obtaining drugs from more than one clinic and the addict could receive only enough drugs to fill his minimum needs. The addict would be allowed to take two days supply with him for self-administration but if caught selling his supply he would be liable to commitment in a hospital. It is felt by its sponsors that the plan, by taking the profit out of illicit narcotic transactions, would allow the addict to become a self-sustaining member of society. With the aura of criminality removed from drug addiction, it should be easier for an addict to be cured and rehabilitated. However, it is pointed out by critics of this proposal that the "tolerance" factor would prevent the stabilization or minimumization of the dosage and the addict would either require increasing dosages or he would turn to the illicit market for more supplies. They also claim that clinics or any plan which provides for the legal distribution of low-cost drugs would foster the growth of a new and larger addict population since addiction is spread, not by the underworld, but by the social exchange between addicts and addict-prone individuals. Although backers of the plan hope that addicts will take the cure, they remove the incentive for him to do so, for under their proposal, the addict would be assured of his supply and would not suffer any moral condemnation. Lastly, it should be mentioned that clinics were tried in the United States in the early 1920's and were closed at the request of the American Medical Association and the Treasury Department when it became evident that they were aggravating the narcotic problem.[67]

b. *The British System*

Another questionable proposal is that the United States adopt the "British System." The British Dangerous Drug Act of 1951[68] is similar to the Harrison Act,[69] but a great difference exists in the manner in which the acts have been interpreted. Although English doctors are not allowed to supply narcotics to patients solely for gratification of their addiction, they are allowed to administer drugs to addicts during the process of cure or when withdrawal symptoms could cause serious permanent injury to the individual's health; where it can be demonstrated that the patient, while capable of leading a relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.[70] The main advantage of this plan is that it places the narcotic problem in the hands of the medical profession and, by allowing the physicians to treat the addict, the major reason for an illicit market disappears. It is claimed by proponents of the British System that the system is the reason that Great Britain has a minute narcotic problem (350 addicts in a population of 50 million).[71] However, a recent and extensive study concluded that "the British system was the result of the favorable British

---

[67] COUNCIL ON MENTAL HEALTH OF THE A.M.A., REPORT ON NARCOTICS ADDICTION 12-44 (Reprinted from 165 J. of A.M.A. 1957).

[68] Dangerous Drug Act, 1951, 14 & 15 Geo. 6, c. 48.

[69] INT. REV. CODE of 1954, §§ 4701-36.

[70] Larimore & Brill, Report to Gov. Rockefeller of an On the Site Study of the British Narcotic System 4 (March 3, 1959).

[71] *Id.* at 15. For a favorable treatment of the British System see Lindesmith, *The British System of Narcotic Control,* 22 LAW & CONTEMP. PROB. 138 (1957).

situation and not the cause of it. . . . The British have a definite abhorrence of narcotic drugs, which has become incorporated into their mores and culture."[72] A comparison of the low English rates of divorce, alcoholism and major crime with ours, serves to demonstrate its sociologically more stable culture.[73] Great Britain does not have large, unassimilated and underprivileged racial minorities living under urban-slum conditions.[74] The opponents of the plan evidence their arguments by pointing to the extensive narcotic problem in Hong Kong, where the British System is employed.[75]

Conclusion

There are few problems that face the courts which have as complex a nature as does the narcotic problem. No enlightened answer will be reached until significant advances in the associated fields of medicine and psychiatry enable investigators to comprehend some of the basic concepts of addiction. The knowledge of why people become addicted, why the rate of relapse is so high and how, if at all, addicts can be effectively cured, must be ascertained before any major change from the present procedure can be advised.

The present system cannot be simply ousted in favor of more humane sounding theories. Our system needs improvement, but a careful study of the problems involved in narcotics addiction reveals that the improvements are being made every day. New institutions must be built to study addiction and treat the addict. The public must be educated as to the danger of addiction and yet learn to treat "cured" addicts with courtesy and respect. Then new laws will be enacted which will liberalize the treatment prescribed for addicts. The Metcalf-Volker Act,[76] recently passed in New York State, should serve as a model for states that can provide up-to-date facilities and a skilled staff which are necessary if the statute is to have any meaning. Every group must apply itself to the reformation of American narcotic policy. The medical profession must be allowed more leeway in its associations with drug addicts because it is the only body capable of making decisions as to the therapeutic efficacy and desirability of treatment procedures. The sociologist must collect more data on a large scale so that legislatures can have definitive information, instead of conjectural hypotheses, with which to work. Recognizing the uncertainty in the fields of causation and treatment, the law should remain flexible in its dealings with addicts. Judges should have wide discretion in treating narcotic offenders similar to the wide discretion they have in sentencing sex offenders. Parole and probation should be used in the treatment of drug addicts because they allow the state to keep constant control over the "detoxified" individual and yet allow the parolee to become a productive ele-

---

[72] Larimore & Brill, *supra* note 70, at 20.

[73] Ausubel, Controversial Issues in the Management of Drug Addiction: Legalization, Ambulatory Treatment and the British System 15 (Paper read at the convention of the Am. Psychological Ass'n, Sept. 4, 1959).

[74] *Ibid.* Only 0.2% of the population of the United Kingdom is of non-caucasian stock, as compared with 16% of the American population. The significance of these figures lies in the fact that two-thirds of the addict population of the United States is drawn from the latter 16%. *Ibid.*

[75] *Id.* at 16. The rate of addiction in that crown colony is twenty-two times that of the United States. *Ibid.*

[76] N.Y. MENTAL HYGIENE LAW art. 9 (Supp. 1962).

ment of society. New York has taken the lead in passing progressive statutes, providing funds for much needed research and in providing modern facilities and procedures for the treatment of drug addicts. Medical, economic and humanitarian considerations demand that the other states and the federal government follow suit.