THE BRITISH SYSTEM OF NARCOTICS CONTROL

ALFRED R. LINDESMITH*

Assuming that there is some relationship between the means adopted by a country to control narcotic drug addiction and the dimensions that the problem¹ subsequently assumes, a consideration of the British system of control should be instructive in light of the relative success of its operation. While the number of addicts in the United States known to the authorities has been estimated to be at least 60,000, only 335 such addicts were reported in the United Kingdom in 1955—about one-third the police-estimated number of addicts in Washington, D. C., alone.² The British system of control—which, incidentally, is quite typical of those commonly used in Western Europe and quite antithetical to our own—allows the addicts to have legal, but regulated, access to low-cost drugs.

I

BRITISH DRUG LAWS

British practices with respect to controlling addiction have not changed materially since 1920, when legislation on this subject was first enacted. This law, known as the Dangerous Drugs Act of 1920,³ with subsequent additions, interpretations, and consolidations over the years, puts addiction and the treatment of addicts squarely and exclusively into the hands of the medical profession. It defines the addict as a patient, treats addiction essentially as a disease, and makes the doctor the final judge as to the circumstances under and manner and quantity in which drugs are to be prescribed. Thus, in the British Government's annual report to the United Nations for 1955, it is stated: "In the United Kingdom, the treatment of a patient is considered to be a matter for the doctor concerned. The nature of the treatment given varies with the circumstances of each case."⁴ Consonant with this conception, there is no compulsory treatment or registration of addicts, and doctors are not

* A.B. 1927, Carleton College; M.A. 1931, Columbia University; Ph.D. 1936, University of Chicago. Professor of Sociology, Indiana University. Presently on leave as a Fellow in the Law and Behavioral Science Program, University of Chicago School of Law. Social Science Research Council Grant, 1955, to study British narcotics control. Author, *OPIATE ADDICTION* (1949). Contributor to sociological journals.

¹ There is, of course, more than one type of narcotics problem, but when reference is made to "the narcotics problem" in the United States, it is generally understood to comprehend only the use of opiate drugs, such as morphine, heroin and their equivalents. Accordingly, it is with this type of drug abuse that this paper is primarily concerned.

² Even if one accepts the minimum estimate of addiction given, there appear to be more drug users in the United States than in all the rest of the western world combined. See Senate Committee on the Judiciary, *The Illicit Narcotics Traffic*, S. REP. No. 1440, 84th Cong., 2d Sess. 2 (1956).

³ 10 & 11 GEO. 5, c. 46.

⁴ HER MAJESTY'S GOVERNMENT IN THE UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, REPORT TO THE UNITED NATIONS ON THE WORKING OF THE INTERNATIONAL TREATIES ON NARCOTIC DRUGS FOR 1955, at 4 (1956).

required to notify the authorities when they begin to treat an addict, although they are encouraged to do so.⁵ Similarly, the National Health Service Act⁶ applies to addicts as to all other types of medical patients, so that the doctor who has addicts in his care receives compensation from the Government for treating them, and the drug user gets his supplies at a nominal cost of one shilling (fourteen cents) per prescription. But an addict securing a regular supply of drugs from one doctor violates the law if, at the same time, he secures drugs from a second doctor without informing him that he is *already* under treatment. The gist of the offense in such a case, it is important to notice, however, is *not* for securing a dual source of supply, but rather for withholding information from the second doctor. Practitioners who provide such dual supplies are, therefore, not in violation of the law.

The act of 1920 and all subsequent laws require that all persons and firms handling dangerous drugs, from manufacturers and importers to pharmacists, doctors, and dentists, be licensed or authorized to do so. These persons are required by law to keep full and accurate records of all drug transactions and to preserve these records for at least two years. Records of retail pharmacies are routinely inspected by the police, while the records of doctors are examined by specially appointed medical inspectors of the Ministry of Health, who are also available for advice on cases of addiction. Pharmacists are required to keep their drug supplies in locked receptacles, and doctors are urged, though not required, to do the same, as far as possible. A doctor is not, however, required to keep a written record of the drugs which he personally administers to a patient—only those which he gives by prescription. If he fails to keep the proper records because, for example, he is trying to cover up his own addiction, he is soon detected by the medical inspectors, because the records will show that he is receiving unusually large quantities of drugs not accounted for by the needs of his patients. Such a practitioner, if convicted of an offense under the Dangerous Drugs Act, can be deprived of his authority to possess, supply, or prescribe drugs, but he cannot be deprived of his right to practice medicine. Among the 335 addicts reported in 1955, there were, incidentally, seventy doctors, two dentists, and fourteen nurses.⁷

There early arose, under the act of 1920, a question of interpretation with regard to a regulation specifying that the doctor was authorized to possess drugs "*so far as necessary for the practice of his profession.*" The Home Office, which has general control over drug law enforcement, interpreted this to mean that doctors were not to be permitted to prescribe drugs regularly for addicts. Indeed, in a 1948 memorandum of instructions to doctors and dentists which is still in effect, the Home Office called attention to the above qualification and added:⁸

⁵ See HOME OFFICE, MEMORANDUM AS TO DUTIES OF DOCTORS AND DENTISTS, DANGEROUS DRUGS ACTS, 1920-1932, at 9 (D.D. 101, 5th ed. 1948).

⁶ 9 & 10 GEO. 6, c. 81 (1946).

⁷ HER MAJESTY'S GOVERNMENT, *op. cit. supra* note 4, at 5.

⁸ HOME OFFICE, *op. cit. supra* note 5, at 4 para. 6.

... a doctor or dentist may not have or use the drugs for any other purpose than that of ministering to the strictly medical, or dental needs of his patients. The continued supply of drugs to a patient, either direct or by prescription, solely for the gratification of addiction, is not regarded as a "medical need"; and in a number of cases doctors who had purchased drugs for the gratification of their own addiction have been convicted of unlawfully procuring and possessing these drugs.

On the other hand, doctors who had previously prescribed regular supplies of drugs for addicted patients continued to do so after the 1920 legislation, in apparent contravention of the law. The Home Office, although aware of this, was reluctant to prosecute, because the matter was felt rather to be one for the medical profession to consider.⁹ As a consequence, in 1924, the Government appointed a committee of prominent doctors, with Sir Humphrey Rolleston as its chairman, to investigate the situation and make appropriate recommendations to the Home Office. The report of this committee, which has since guided the interpretation and enforcement of the law, affirmed the right of doctors to provide drug users with regular supplies of drugs and, in effect, defined this practice as "treatment" rather than as the "gratification of addiction".¹⁰

... morphine or heroin may be properly administered to addicts in the following circumstances, namely, (a) where patients are under treatment by the gradual withdrawal method with a view to cure, (b) where it has been demonstrated, after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced, (c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.

The committee also made other recommendations for the guidance of doctors who handle drug users, which, although lacking the force of law, exert a profound influence upon medical practice.¹¹ They include warnings that the gradual withdrawal method of cure should be undertaken in an institution or nursing home, that the patient should be in the hands of a reliable and capable nurse, that a second medical opinion should be secured before the decision to administer drugs indefinitely is made, that the quantity of drugs prescribed should be carefully controlled, and that drugs should not be administered to a new patient who requests them without prior medical examination and relevant information from the doctor who previously handled the case.

⁹ See DEPARTMENTAL COMMITTEE ON MORPHINE AND HEROIN ADDICTION, REPORT TO THE MINISTRY OF HEALTH I (1926).

¹⁰ HOME OFFICE, *op. cit. supra* note 5, Appendix A at 10.

¹¹ If the doctor does not know of these recommendations, the Home Office may call them to his attention. If he does know about them and disregards them, pressure can be exerted upon him by the medical inspectors of the Ministry of Health and by medical bodies, such as those which administer the National Health Service Act. Continued recalcitrance could theoretically lead to disciplinary measures by a medical tribunal authorized under the regulations for this purpose. Actually, no such tribunal has ever been convened.

Concerning incurable cases of addiction the committee observed:¹²

They may be either cases of persons whom the practitioner has himself already treated with a view to cure, or cases of persons as to whom he is satisfied, by information received from those by whom they have previously been treated, that they must be regarded as incurable. In all such cases the main object must be to keep the supply of the drug within the limits of what is strictly necessary. The practitioner must, therefore, see the patient sufficiently often to maintain such observation of his condition as is necessary for justifying the treatment. The opinion expressed by witnesses was to the effect that such patients should ordinarily be seen not less frequently than once a week. The amount of the drug supplied or ordered on one occasion should not be more than is sufficient to last until the next time the patient is to be seen. A larger supply would only be justified in exceptional cases, for example, on a sea voyage, when the patient was going away in circumstances in which he could not be able to obtain medical advice. In all other cases he should be advised to place himself under the care of another practitioner.

The Home Office annually reports the number of persons known to be using drugs regularly. It maintains a file in which the cases are classified into two sections—medical and nonmedical. The former contains data concerning persons regularly receiving drugs because of disease, such as cancer patients; the latter, persons who are simply addicts—that is, persons who are receiving drugs primarily because they are addicted to them and not because of disease or any other medical condition. The figure of 335 known addicts in 1955, mentioned previously, was evidently secured by counting the number of cards in the nonmedical section and represents an increase of eighteen over the previous year.¹³ At latest reports, the number of cases in the medical section also numbered a little over 300—337 to be exact.¹⁴ The information recorded in these files is obtained from data voluntarily supplied by pharmacists and doctors, as well as from regular inspection of their records.

Sceptics are likely to inquire whether the Government's figure of 335 addicts for a country with a population of more than fifty million people can be taken as any real indication of the actual number of drug users. Might there not be a considerable number of concealed addicts who secure their drugs entirely from illicit sources? Officials interviewed by the writer admitted the existence of such addicts but refused to estimate their number. It was said that there were drug peddlers and traffickers in the Soho district of London; but, it was argued, the extent of the traffic was quite small, even in such large cities as London and Liverpool, and it was practically nonexistent in other cities. It was also contended that this market is mainly concerned with drugs such as marijuana and cocaine, which are not regularly prescribed by doctors and are prohibited in the United Kingdom, as they are in the United States. Two medical men who were interviewed estimated that there were ten unknown addicts for every one that is known to the authorities; but other doctors and almost all government officials who ex-

¹² HOME OFFICE, *op. cit. supra* note 5, Appendix A at 10.

¹³ See HER MAJESTY'S GOVERNMENT, *op. cit. supra* note 4, at 5.

¹⁴ COMMISSION ON NARCOTIC DRUGS, ECONOMIC AND SOCIAL COUNCIL, SUMMARY OF ANNUAL REPORTS OF GOVERNMENTS 1949, at 17 (U.N. Pub. Sales No. 1951.XI.5).

pressed an opinion regarded this estimate as extravagantly high and totally unreliable.

Among the reasons for believing that the number of concealed addicts is not large is the fact that very few addicts are sent to prison each year. During the last five years, the number of addicts sent to prison for any offense whatever has run as follows: in 1952, there were six; in 1953, sixteen; in 1954, eleven; in 1955, eleven; and up to July 1956, eleven.¹⁵ These figures do not suggest the existence of any large number of addicts among the criminal elements. When the writer observed to a Scotland Yard officer that pickpockets and shoplifters in the United States were frequently addicted, the officer ventured the opinion that there was not a single addicted pickpocket in London. Probation, parole, and prison officials and doctors are largely unacquainted with the addiction problem from personal experience. A police officer with twenty years' experience outside of London stated that he had encountered only one narcotics case, and it involved an American soldier who used marijuana.

The black market in drugs, such as it is, appears to be very different from that in the United States. Thus, the 1955 government report states: "The 'addict' who is also a 'pusher' is unknown in the United Kingdom, though on occasions an addict may procure more than his own requirements in order to supply his friends."¹⁶ It is also stated that the black market in Britain is not "organized," that it subsists to a considerable extent on addicts who wish to supplement their legally obtained dosage, and that it is supplied, primarily, by drugs unlawfully secured from legitimate sources—for example, from unethical or unscrupulous doctors. A London physician estimated that there were, perhaps, five or six such doctors in London. In the Government's 1955 annual report to the United Nations, the following statements about the illicit traffic occur:¹⁷

The gradual decline in the traffic in opium, noted in the report for 1954, continued, and both the number of seizures of this drug, and the quantity confiscated, were the lowest for several years. . . . Illicit production of manufactured drugs and traffic in such drugs obtained from illicit sources is unknown. Isolated cases of the theft of legitimately manufactured drugs occur very occasionally, but in 1955 no such cases were reported. There were, however, some instances of addicts obtaining supplies from lawful sources by illicit means, for example, by forged prescriptions.

The Dangerous Drug Act of 1951 prescribes penalties as follows:¹⁸

Every person guilty of an offense against this Act shall, in respect of each offence, be liable—(a) on conviction on indictment, to a fine not exceeding one thousand pounds [\$2,800], or to imprisonment for a period not exceeding ten years, or to both such fine and imprisonment; or (b) on summary conviction, to a fine not exceeding two hundred

¹⁵ Unpublished figures given the author by a Home Office official.

¹⁶ HER MAJESTY'S GOVERNMENT, *op. cit. supra* note 4, at 5.

¹⁷ *Id.* at 6.

¹⁸ Dangerous Drug Act, 1951, 14 & 15 GEO. 6, c. 48, § 15.

and fifty pounds [\$700], or to imprisonment for a term not exceeding twelve months, or to both such fine and imprisonment. . . .

A qualification of the above is that anyone convicted for inadvertently violating the regulations for the dispensing of prescriptions and keeping of books cannot be sentenced to prison without the option of paying a fine of not more than fifty pounds. No mandatory penalties are prescribed; it is left to the court to fix the precise penalties in accordance with the circumstances of the case and the nature of the offense. In practice, the maximum penalties are scarcely ever applied.¹⁹ The court is also free to place the defendant on probation, and often does. A judge may place an addict on probation on the condition that he agree to accept treatment from a doctor.

In 1955, the actual sentences of imprisonment imposed for offenses involving manufactured drugs ranged from six weeks to twelve months; for those involving opium, from twenty-eight days to six months; and for those connected with marijuana, the range was from one day to three years.¹⁹ Maximum fines for these categories of offenses were equivalent, respectively, to \$140, \$280, and \$140. By comparison with American practice, these penalties are extremely light, and one might suppose that they would have little or no deterrent effect. It must be remembered, however, that laws carrying mild and flexible punishments are more likely to be enforced than those imposing harsh, inflexible penalties.

During 1955, 184 persons in the United Kingdom were prosecuted for violations of the dangerous drugs laws.²⁰ Of these, 169 were convicted—seventeen for offenses involving opium, 115 for offenses involving marijuana, thirty for offenses connected with manufactured drugs, and seven because they failed to keep drugs in locked receptacles or did not keep proper records. Sixteen of the seventeen offenses involving opium were committed by Chinese, usually opium smokers, who had prepared or raw opium in their possession, ostensibly for smoking, a practice expressly forbidden by British law. Persons convicted in the marijuana cases were largely of Asiatic, West Indian, and West African origin, and about eighty-five per cent of the cases occurred in Liverpool and London. The thirty convictions involving manufactured drugs were cases where the defendants were all British subjects of European origin, and most of them were addicts. Their offenses consisted mainly of forging prescriptions or obtaining prescriptions simultaneously from more than one doctor.

The nature and number of the offenses noted above gives no support to the idea that a considerable number of unknown addicts exists in the United Kingdom; rather, it supports the view of officials that the black market is of such a nature that an addict cannot rely on it indefinitely for his supplies. Even if he escapes arrest, it is felt that he will soon be forced to go to a physician. When he does, and the doctor prescribes for him, his name appears on the prescription and on the doctor's register—

¹⁹ See HER MAJESTY'S GOVERNMENT, *op. cit. supra* note 4, at 6-7.

²⁰ *Ibid.*

in short, he becomes a known addict. British officials are confident that if there were a substantial number of addicts depending upon the black market for their supplies, the situation would be bound to come to the attention of the law enforcement authorities.

The facts as explained are bound to raise two questions in the mind of any American familiar with the problem of narcotics control. Why is there a black market at all in a country where users can obtain low-cost, legitimate drugs? And why do not all addicts go to physicians for their drugs? To answer these questions, the writer made extensive inquiries during the summers of 1955 and 1956 while he was in England. A doctor in London, who had considerable first-hand knowledge of addicts, said that one answer to these questions was that some addicts patronizing illicit sources were unaware that they could secure drugs from doctors. He urged a publicity campaign to inform them of this. Other addicts fear becoming known to the authorities and avoid medical men for that reason. Again, the responsible physician is apt to require, as a condition for accepting the addict as a patient, that he agree to cooperate in a treatment program designed to achieve a cure. The doctor may also ask the addict's permission to inform the Home Office of his case at once, since the case will come to the attention of the authorities anyway as soon as the doctor's register is next examined. Addicts who are unwilling to accept these conditions may prefer to depend upon illicit sources in spite of the much higher costs to them.

In order fully to understand the manner in which the drug problem is handled in Britain, it is necessary for an American to appreciate that the entire problem is given very little publicity. The Home Office officials and the police officers who deal with it are largely unknown to the general public. Their pictures do not appear in newspapers and magazines, nor are their accomplishments glorified in the movies and the press. The effect has been to induce the public generally to regard the details of medical treatment for addicts as technical matters to be settled by discussions among experts, rather than by public debate. It has also prevented the public, and sometimes also journalists, doctors, and addicts, from knowing much about how the drug problem is actually dealt with.

II

LAW ENFORCEMENT

Enforcement of the British drug laws is centered in the Dangerous Drug Branch of the Home Office, which is a nonpolice branch of the Government exercising general control over police policy and cooperating closely with the police, the medical profession, pharmacists, and the Ministry of Health. A small narcotics squad in the London Police Force is assigned on a full-time basis to the narcotics problem, and the regular police are also empowered to arrest violators. As noted above, pharmacists' records are routinely inspected by the regular police, who report their findings

to the Home Office. Inquiries to doctors and inspection of their records are made by the Home Office and by specially appointed regional medical inspectors. If violations of the law are suspected or discovered, the police may be brought into the case to conduct further investigations. If no violation of the law exists, but it is felt that a doctor's handling of the case is not up to standard, pressure is apt to be exerted upon him through medical channels—for example, a medical inspector may call upon him to give advice, since that is one of the functions of these inspectors. Doctors are sometimes convicted of offenses involving improper prescriptions or records, for instance, when they are trying to cover up their own addiction.

During the summer of 1955, the writer attended a hearing in a London magistrate's court on the case of a London doctor charged with violating the law by aiding and abetting an addict in the deception of a doctor. It was established that the addict had received about six grains of heroin daily from each of two doctors. He had died early in 1955, and the cause of death at the inquest was stated to be an overdose of heroin. The magistrate who heard the case dismissed the charges with the following comment:²¹

It may well be that the patient committed an offence here. It is not for me to decide one way or the other, but to my mind it would make nonsense of these regulations, which are designed to give duly qualified medical practitioners absolute discretion as to how they treat their patients and the quantities of drugs they shall prescribe, if I were to hold that these facts amounted to an infringement of these regulations by this defendant.

There is nothing in these regulations to which my attention has been directed which limits the quantities of drugs which may be lawfully prescribed by a doctor. It may well be that this conduct of the defendant was gravely improper. It is not for me to decide any such issue.

It may be that it is a matter which may be referred to the disciplinary body of the medical practitioners, but I have no doubt that the prosecution have failed to establish a *prima facie* case against this defendant of aiding and abetting another person to be in possession of this dangerous drug and I therefore dismiss the information.

During the course of the hearings on this case, a woman who was said to have been an addict in the past appeared as a witness. She stated that she was now respectably employed and was no longer an addict and asked that her name be withheld. When she appeared on the witness stand, her name was, accordingly, written on a slip of paper and handed to the magistrate, but was not mentioned publicly. This incident is representative of the attitude generally taken toward drug users. The public attitude may best be described as pity. When addicts appear in court charged with criminal offenses, if they are treated differently at all from other offenders, they are apt to be dealt with more lightly. An addict who secures additional supplies of his drug by forging prescriptions or secretly consulting a second doctor will usually only be fined if he is not a chronic offender. If he is old and ill besides, he may merely be placed on probation. If, however, an offender against the drug laws

²¹ Quoted in *The London Times*, Sept. 9, 1955, p. 5, col. 2.

is thought to be operating from mercenary motives, for his own financial gain, he is apt to be dealt with more severely by being sentenced to prison.

In 1954, an incident occurred which epitomizes the manner in which the British drug laws operate. An American entertainer performing at the London Palladium, a vaudeville theater, was known by the police to be a heroin user and was, therefore, watched. This person consulted a doctor from whom he received a prescription for heroin under a false name and identity. He was arrested, charged, and convicted for having given false information to the physician, and then deported. The writer asked what would have happened had the defendant not given false information to the doctor. The answer was that in that case, nothing would have happened, because there would have been no violation.

III

THE BAN ON HEROIN

The recent attempt of the British government to impose a ban on the manufacture and importation of heroin affords an excellent illustration of the sensitivity of the British medical profession to what it regards as encroachments on its prerogatives. Heroin was banned in the United States in the twenties,²² when it was discovered that addicts were using this drug very widely. Since the heroin that was being used by American addicts at this time was already being used illegally, the ban had no particular effect; in fact, heroin has become even more popular with American users since, but not because, it was banned. The congressional hearings held before the ban was put into effect revealed that the medical profession in this country was divided on the question of the medical usefulness of heroin.²³ The majority declared that heroin was not indispensable; a minority, however, contended that heroin did have some therapeutic values not possessed by possible substitutes and argued against the ban. This minority opinion was brushed aside, of course, by congressional action. Shortly thereafter, similar hearings were held in Britain which revealed a similar split in British medical opinion; but Parliament interpreted this as a reason for *not* imposing a ban, because the medical profession was not in agreement.

In recent years, American representatives to the World Health Organization of the United Nations spearheaded an international drive to ban heroin everywhere; and it is now an illegal drug in more than fifty countries of the world. It was the pressure of this drive that probably caused the British Government to announce, rather suddenly in 1955, that the manufacture of heroin would be discontinued in 1956. Protests from medical sources were voiced immediately, and the issue was vigorously discussed in newspaper columns and in letters to the editor. The matter became a minor political issue in Parliament, and the part played by American pressure in

²² 43 STAT. 657 (1924), as amended, 46 STAT. 586 (1930), 21 U. S. C. § 173 (1952).

²³ *Hearings before the House Ways and Means Committee on H. R. 7079, Prohibiting the Importation of Opium for the Manufacture of Heroin*, 68th Cong., 1st Sess. (1924).

the campaign to outlaw heroin was understood and discussed. The vigorous reaction of the British medical profession to the Government's action was based more on the feeling that the Government was interfering with the rights of the profession than on any attachment to heroin as a therapeutic agent. The Government was eventually obliged to postpone the banning of heroin to an indefinite date, and heroin is, therefore, still not a contraband drug in the United Kingdom, as it is in the United States.

IV

EFFECTS OF THIS SYSTEM ON THE DRUG PROBLEM

It would, of course, be a mistake to attribute the trivial nature of the British drug problem entirely to the control measures which have been sketched. Back in 1920, when present control measures were set up, the number of addicts in Britain was small, in contrast with the situation in this country. Nevertheless, the facts that the problem has diminished since that time and that the number of drug users is probably close to what one might call "an irreducible minimum" are strong arguments in favor of the British system.

Prior to 1920, English addicts were free to buy their supplies of drugs from pharmacies without consulting a doctor. After that time, they were compelled either to give up the habit or to consult a physician. They had a third alternative, to obtain supplies from illicit sources, but this was scarcely practical, because no illicit traffic that was sufficiently organized to provide regular supplies ever developed. By having to turn to doctors, addicts got the benefits of medical and psychiatric care and advice. Although the drug user is a difficult patient to handle, he is obviously better off in the hands of the medical profession than if left to his own devices.

British officials are concerned over the potential development of a clandestine traffic as it exists in the United States but feel, in the main, that giving addicts access to low-cost, legitimate drugs takes most of the economic motive out of such a traffic. At the same time, it is realized that the addict's access to drugs cannot be too free and unrestricted; hence, the pressure on doctors to minimize dosage and to make prolonged attempts to achieve a cure. Undoubtedly, there is some objection in Britain on moral grounds to indefinite administration of drugs, but this is counter-balanced by consideration of the greater evil of a large illicit trade in the hands of criminals. That the present system seems to work, in the sense that the problem is small and not growing larger, causes an understandable reluctance to change it in any important way.

English officials and the public do not regard addicts as criminals, since their addicts are not criminals, or are so in only a minor sense of the term. They, therefore, have difficulty in understanding the American tendency to equate addiction with criminality and to punish addicts more and more severely. It is rather felt in Britain that the addict is a weakling or an unfortunate person to be pitied and treated with compassion.

Since the British addict does not need as much money to secure drugs as he does to buy cigarettes, he does not have to steal, become a prostitute, or peddle drugs in order to support his habit. Indeed, there is a positive special hazard and unnecessary disadvantage for him in such criminal activities, since they may lead to entanglements with the law and to sudden interruptions of his habit. It is also disadvantageous for the criminal to become an addict, for he thereby adds greatly to the hazards of an already perilous occupation. A London police officer was asked what might happen if one approached a prostitute to inquire about illicit heroin. He suggested that she might well report to the police, since she knows that if she sticks to prostitution alone, the worst that will happen to her is that she will be fined forty shillings about every two weeks; whereas if she becomes involved with drugs, she might go to prison.

Because the British addict can maintain his habit without becoming a criminal, and the criminal is not especially exposed to addiction by the existence of a large, illicit, traffic or by great numbers of addicts in the underworld, these two groups remain relatively separate. This works not only to the public advantage, but also to their own. It should not be surprising, therefore, that London thieves show no special tendency to become drug addicts, or that London addicts are relatively non-criminal.

It is interesting that the use of marijuana, which, in this country often leads to the later use of heroin, does not seem to have this consequence in Britain. There, marijuana smokers obtain their supplies entirely from illicit sources, and the British police deal with this problem much as it is dealt with here. The fact that heroin, on the other hand, is not contraband and that it may be prescribed for those addicted to it may account for this difference in the use of the two kinds of drugs.

It has been said that British addicts do not show the same disposition as their American counterparts to spread their vice, but instead warn others who may become interested in it. On this point, several aspects of the situation are relevant: One is that in England, there is little or no economic incentive to spread the habit to others. Further, if the addict is under a doctor's care, he will certainly want to keep the supplies he receives rather than sell or give them away; if he sells them, he violates the law. Moreover, if the addict is under a doctor's care, he can keep his habit from becoming publicly known, since all records with respect to it are confidential. Thus, he risks forfeiting his anonymity, as well as his status as a law-abiding citizen, if he violates the law.

A frequent criticism of the British program is that it does not place sufficient stress upon curing addicts, because drugs are made available to them and because they cannot be compelled to seek cures. In answer to this, it is argued that compulsory cures are ineffective anyway and that a drug addict, like a person addicted to alcohol, can only be cured if he wants to be and cooperates in the process. By putting the drug user in the hands of a doctor and by not removing him from his community and family, the British program maximizes the resources which may be

drawn upon for effective treatment by persuasion, rather than by coercion. Nevertheless, no really effective method of curing drug addiction has been found in any country of the world.

It is sometimes believed that controlled legal distribution of low-cost drugs to addicts would make drugs easily available and lead to the rapid spread of the habit. It has not done so, of course. This belief is based upon the mistaken premise that drugs made available by a doctor's prescription are generally easy to get. Such drugs are readily available to the addict diagnosed by doctors to be in need of them, but they are relatively inaccessible to all others. It is difficult to imagine a teen-ager approaching a doctor to ask for a large quantity of heroin with which to entertain his friends. It is even more difficult to think that a doctor would accede to such a request. It is because addicts can obtain drugs by prescription that those drugs are unobtainable otherwise.

The system of narcotic drug control in Britain which we have discussed is obviously based upon the premise that the medical profession, with a certain amount of instruction, experience, and supervision, can be trusted to carry out its obligations in good faith under a scheme of this kind. It is quite true that much responsibility is placed upon the individual doctor and that this responsibility has sometimes not been met. An English doctor made the point that any scheme is bound to be abused to some extent and that there are some irresponsible persons in all occupations. He did not believe, however, that there was any sense in abandoning a good program because of this small minority or in making a new program adapted to the low ethical standards of this small minority. Specifically, he felt that measures which would keep the few irresponsible doctors in Britain in check and punish them for unethical practices in respect to addicts would set dangerous precedents and be detrimental to the medical profession as a whole.

On humanitarian and legal grounds, the British system may be defended as a just and humane one. Because the addict does not also have to be a criminal, it is made reasonable and just to punish him when he does offend. Addiction itself is not a crime, in either theory or effect, and the addict is never formally punished for it. On the contrary, the idea of such punishment is rejected by public and official opinion as contrary to the principles of British law and common humanity. Because the addict, as elsewhere, is regarded as an ill, weak, troubled, and unfortunate person, fines and prison sentences are not considered appropriate ways of dealing with him. He has, moreover, the same legal protection and rights in court as anyone else, and he is not deprived of them by legal technicalities or subterfuges. As a doctor's patient, he has the same standing as any other patient—as already mentioned, all official records are confidential; and as a matter of practice, special care is taken to protect the addict from unnecessary exposure or publicity. Perhaps ultimately the greatest strength of the system lies in the fact that it is publicly recognized to be just and humane.

V

MISCONCEPTIONS OF THE BRITISH SYSTEM

During recent years, there has been a growing interest in the United States in the methods of drug control used in West European countries, especially in Britain.²⁴ Perhaps because the practices of these countries are different from our own and seem to be more successful, American officials have not invited invidious comparisons by publishing information about them. In some instances, false information has been disseminated.

A prevalent misconception equates the so-called "clinic system," as used in the United States in the early twenties, with a program such as that described in this paper. The alleged failure of the clinic idea in the United States is then cited as proof that any legalized distribution of drugs to incurable addicts must fail. There is, however, little resemblance between the clinic idea and the British program, and any attempt to treat them as similar leads only to confusion.

In a recently published book on the narcotics question,²⁵ Mr. Harry J. Anslinger, Commissioner of Narcotics, contributes to this kind of confusion by discussing the clinic plan under the heading "Fallacy of Legalizing Drug Addiction." He describes such a plan as follows: "Under this plan anyone who is now or who later becomes a drug addict would apply to the clinic and receive the amount of narcotic drug sufficient to maintain his customary use."²⁶ He does not describe the British system or that of any other West European country. Concerning the British system he writes:²⁷

No government in the world conducts such clinics, no matter what is said about England. What about all the seizures there? What about the trouble doctors are having keeping their bags from being stolen?

Comment:

The latest official report of the British Government, for 1955, states, concerning the questions raised by Mr. Anslinger:²⁸

There were no seizures of manufactured drugs. . . . Isolated cases of the theft of legitimately manufactured drugs occur very occasionally, but in 1955 no such cases were reported.

As far as nonmanufactured drugs are concerned, fourteen seizures of opium and forty-eight of marijuana were reported for 1955.²⁹

Elsewhere in his book, Mr. Anslinger refers to "The present wave of drug addic-

²⁴ For a recent example, see Kolb, *Let's Stop This Narcotics Hysteria*, Saturday Evening Post, July 28, 1956, p. 19.

²⁵ HARRY J. ANSLINGER AND WILLIAM F. TOMPKINS, *THE TRAFFIC IN NARCOTICS* (1953).

²⁶ *Id.* at 185-86.

²⁷ *Id.* at 290.

²⁸ HER MAJESTY'S GOVERNMENT, *op. cit.* *supra* note 4 at 6.

²⁹ *Ibid.*

tion in the United States, Canada, Turkey, Egypt, England, Germany, and Japan,"³⁰ and makes the following specific remarks about England:³¹

In England, the British Government reports annually only 350 drug addicts known to the [British] authorities—mostly doctors and nurses. When we ask them about the statistics on seizures of opium and hashish [marihuana], they say: Negroes, Indians, and Chinese are involved. In this country, we don't distinguish; we take the situation as a whole. England, during the past year, has had a surge of hashish addiction among young people. A year ago they were looking at the United States with an "it can't happen here" attitude. Suddenly hashish addiction hit the young people. Ordinarily hashish is only something for the Egyptian, the Indian. Now the British press is filled with accounts of cases of addiction of young people.

Comment:

Apart from the fact that marijuana, or hashish, is not a drug of addiction in the sense that the opiate derivatives are, it should be noted that the number of persons prosecuted for offenses involving marijuana reached a peak in Britain in 1954 with a total of 152. In 1955, there were 115 such cases. The number of these offenders who were of European origin was twenty-nine in 1954.³² These figures scarcely seem to justify the use of the word "surge" in describing the British situation.

Some deliberate attempts to misrepresent the nature of the British system have also been made. In an anonymous mimeographed statement entitled *British Narcotic System*, distributed free of charge at the meeting of the American Prison Association in Philadelphia in 1954, the following statements appear:

The British system is the same as the United States system. The following is an excerpt of a letter dated July 18, 1953, from the British Home Office, concerning the prescribing of narcotic drugs by the medical profession:

"A doctor may not have or use the drugs for any other purpose than that of ministering to the strictly medical needs of his patients. The continued supply of drugs to a patient, either direct or by prescription, solely for the gratification of addiction, is not regarded as a medical need.

Comment:

This quotation is extracted from the 1948 Home Office memorandum and has been discussed in some detail above. The failure here to explain that the Rolleston Report interpreted regular administration of drugs to an addict by a medical practitioner to be treatment, rather than the "gratification of addiction" gives the statement the opposite of its actual meaning.

Other statements from this document on the British system and clarifying comments follow:

³⁰ ANSLINGER AND TOMPKINS, *op. cit. supra* note 25, at 11.

³¹ *Id.* at 279.

³² See HER MAJESTY'S GOVERNMENT, *op. cit. supra* note 4, at 7; and HER MAJESTY'S GOVERNMENT IN THE UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, *THE TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS, REPORT TO THE UNITED NATIONS FOR 1954*, at 4-5 (1955). In 1951, the year referred to by Mr. Anslinger, the number of marijuana cases was 127.

No doctor would give a prescription for marihuana in the United Kingdom as he would be charged with a narcotic violation.

Comment:

A doctor would not, of course, prescribe a marijuana cigarette, but he could, conceivably, prescribe marijuana in some other form without violating any law, since prescriptions of drugs are subject to control by medical practice and not by law.

There is also a black market for morphine and pethidine in the United Kingdom. Twelve per cent of the illicit trafficking cases in the United Kingdom related to forged prescriptions or *concurrent supplies from more than one doctor* to obtain morphine or pethidine to gratify addiction. The British government arrests these addicts who forge prescriptions for morphine and pethidine. They are handled the same way in the United States. (Italics not in original.)

Comment:

The italicized part of this statement shows that the unknown author was aware of the fact that British addicts can obtain supplies legally from one doctor. The number of persons represented by "twelve per cent" was fourteen;⁸³ and there was probably no connection with the illicit traffic. Addicts who forge prescriptions and obtain dual supplies do so, as a rule, to supplement the supplies they receive legally.

There are also robberies by addicts of drug stores or other establishments handling narcotics in the United Kingdom.

Comment:

There are few such cases, and in 1955, there were none reported.

There follows a brief discussion of the clinic plan in the United States, indicating that it failed and that the American Medical Association opposed it. The final sentence in this anonymous statement reads:

A pamphlet, "Narcotic Clinics in the United States" giving the history of the opening and closing of clinics, can be obtained free of charge by writing to the Bureau of Narcotics, Washington, D. C.

Comment:

It would appear that any discussion of the clinic plan in the United States under the heading *British Narcotic System*, is highly irrelevant, since there are no clinics in the British system.

The idea of allowing morphine or heroin addicts to have access to legal drugs is often represented in American magazines and the press as a daring and revolutionary conception. It is nothing of the kind. It is the principle on which American practice was based until about 1920 and on which most drug control schemes in the western hemisphere are still based. The annual reports of European nations to

⁸³ As checked by a Home Office official who read the mimeographed statement.

the drug control bodies of the United Nations demonstrate this.³⁴ Methods for internal control of the drug problem are not dictated by the United Nations and are rarely discussed in its publications, probably because of various national sensitivities, including particularly American sensitivity, on this question.

Because of his position as Commissioner of Narcotics, head of the Federal Bureau of Narcotics, and American representative to the United Nations on drug control matters, the opinions of Mr. Harry J. Anslinger are of special importance. They are often echoed by congressional committees and by the press and are influential in shaping public opinion. Mr. Anslinger has been consistently and strongly opposed to any form of legalized distribution of drugs to addicts. He has, however, never described the British program, but has leveled his blasts at the clinic plan instead.

Some of his objections to the clinic plan are as follows:³⁵

This plan would elevate a most despicable trade to the avowed status of an honorable business, nay, to the status of practice of a time-honored profession; and drug addicts would multiply unrestrained, to the irrevocable impairment of the moral fiber and physical welfare of the American people.

....

[Such a plan] is . . . in direct contravention of the spirit and purpose of the international drug conventions, which the United States solemnly entered into along with *seventy-two other nations of the world*. . . .

....

[It would be a] reversion to conditions prior to the enactment of national control legislation and a surrender of the benefits of twenty-four years of progress in controlling this evil, in which control the United States has been a pioneer among nations.

....

. . . to establish clinics in countries which have a narcotic drug problem would be as sane as to establish infection centers during a smallpox epidemic.

....

It is believed that easy or unrestricted access to drugs tends materially to increase addiction.

Comment:

Not a single one of these objections is applicable to the program now in force in the United Kingdom and in most other countries of Europe. In the first place, none of them has clinics. All or most of them are also parties to the same international agreements that the United States has entered into, and all of them combined do not have as many addicts as the United States. The systems do not give "easy or unrestricted access to drugs" and have apparently controlled the spread of addiction, especially among young persons, far more effectively than has the American program.

³⁴ COMMISSION ON NARCOTIC DRUGS, ECONOMIC AND SOCIAL COUNCIL, SUMMARY OF ANNUAL REPORTS OF GOVERNMENTS (published annually).

³⁵ ANSLINGER AND TOMPKINS, *op. cit.* *supra* note 25, at 186, 189, 190-99.

VI

CONCLUSIONS

The very success of the British and other similar European programs of narcotics control has been a factor in preventing them from being widely known in the United States. The number of heroin and morphine addicts in Britain, for example, is so small that very few persons there have specialized knowledge of this subject. The literature is extremely scanty, consisting mainly of official reports and a few widely scattered articles in medical journals.³⁶ Many of these works are not illuminating to American readers, because they take for granted a knowledge of British medical practices. However, the apparent success of medically controlled, legalized distribution of drugs to addicts there is of obvious special significance for the United States.

It would be rash to advocate any wholesale, indiscriminate importation of British methods to this country in the expectation of an immediate solution to the drug problem. The relatively large number of addicts here and their concentration in big cities and in certain segments of the population clearly present special problems of extraordinary difficulty, as does the existence of a large-scale illicit traffic of many years' standing. Nevertheless, with due allowance for the differences in customs and social organization that exist between the two countries, it is reasonable to suppose that there is much in British experience from which we could profit. Drug addicts, after all, are pretty much the same throughout the world in many essential respects. Allowing for the smaller number of them in Britain, they still do not constitute the social evil there that they do here. The trend in the United States toward more and more severe punishment, for users and peddlers alike, has reached such an extreme, that demand for a fundamental re-evaluation of the present punitive program is very much in order. When it is undertaken, British experience could, and should, play an important role.

³⁶ There is only one book on narcotics known to the writer which contains a fairly adequate description of the British system of narcotics control, EDWARD W. ADAMS, *DRUG ADDICTION* (1937).