The Problem of Drug Addiction

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THE social problem of narcotic addiction and the ethical issues surrounding it are very complex. This necessarily limits the scope of this article. A short background of the problem will be given, followed by a discussion of the proposals for solution. It is hoped that the result will be an analysis of the problem with some evaluation of the possible solutions open to society.

The problem must be understood in light of the two basic schools of thought opposing one another to a large degree. The first is the school headed by the U.S. Bureau of Narcotics which regards addiction as subject to police control and solution. The other school now rallies around the recent report by the Joint Committee of the American Medical Association and the American Bar Association and stands opposed to the philosophy of the first group. Very little synthesis has come out of this bitter dialogue.

The Problem

Everyone seems to agree on the definition of narcotic addiction as the one adopted by the World Health Organization:[1]

> Drug addiction is a state of periodic and chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:
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> (1) An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
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> (2) A tendency to increase the dose;
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> (3) A psychic (psychological) and sometimes physical dependence on the effects of the drug.

Like alcoholism, addiction to narcotics is difficult to characterize. It is a disease from the standpoint that its physical effects are a disease process in the body. But it is more than this in that it is also a pathological condition or a symptom of personality difficulties. The motivation for the use of narcotics is often psychologically rooted in the needs of the individual. The problem also has its socio-economic and legal aspects, making it a social as well as personal problem. In withdrawal there is also a sickness syndrome that is quite serious, and it is this syndrome that provides the chief motivation for continuing the habit — to avoid the severe distress of withdrawal.

There are generally three types of addicts. The first is called by the police the "street-addicts" or the addicts we usually think of in terms of this problem. This is the largest and most difficult group. The second would be the "accidental" addicts who have become addicted to drugs used to alleviate their pain connected with disease or injury. The third group is the professional people in medicine who have become addicted, but rarely pose a serious social problem because of their status and economic position.

A special group of addicts that touch us all more directly are the rapidly growing number of people addicted to barbiturates or "sleeping pills." This has become a serious problem because these drugs are widely available and because they are dangerous. "More people in the United States die of barbiturate poisoning than from any other kind of poison. Moreover, withdrawal of barbiturates from addicted persons

[1] Joint Committee of the American Bar Association and American Medical Association on Narcotic Drugs. *Drug Addictions Crime or Disease?* Bloomington: Indiana University Press, 1961, p. 23.

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is accompanied by extremely severe and dangerous symptoms."[2]

Contrary to popular opinion, regular narcotic addiction has few harmful physical effects in itself. "The facts tend to indicate that the use of drugs like heroin and morphine is consistent both with a reasonable state of health and with a reasonable degree of efficiency on the part of the individual user."[3] It is rather the lack of the drug and the struggles necessary to get it that cause severe physical distress. The addict has a feeling of normality that goes along with his actual state. In fact, some "gutter" alcoholics have considerably improved their social lives when they switched to narcotics.

There are some physical effects of addiction that might be considered undesirable. Drugs cause a loss of appetite which may lead to neglect of nutrition with resulting complications such as emaciation and anemia. The addict may not eat very well because he must spend most of his money on drugs rather than food. Drugs also lower the urge for sex a great deal — exploding the myth of the drug addict as a sex fiend or lecher. Much physical harm may be caused by the improper handling of dirty and unsterile tools to apply the drugs. These include scarring, abscessing, blood poisoning, etc. There is also the risk of death from a sudden overdose of the narcotics.

While it cannot be said that narcotics make a person function **better** as a human being, the drugs do not impair his **adequate** functioning to any great degree. However, some of the side effects of the habit are less than desirable though they may often be alleviated while still continuing to use drugs.

While physically, addiction is a disease from the standpoint of need for the drug, there are many psychological aspects — especially in the selection of those who become addicted. Research in this area is in the beginning stages and the addictve personality, like the alcoholic personality (alcoholism is a specific kind of narcotic addiction), has not been isolated. Many use drugs to compensate for shortcomings in their personality, to escape from the anxieties and tensions of life. But there is no one pattern as the personality disorders of addicts come from all the categories of psychiatric classification. "Normal" people also become addicts, especially those in the "accidental" category. It is probable that the largest number of addicts would fall in the psycho-neurotic and psychopathic categories, but this is not universally true.

Narcotic addiction has many social ramifications. First, the addict, while not incapable of functioning in a somewhat normal way, is generally lethargic, undependable, and devoid of ambition. He would not fit society's definition of a useful and productive personality.

But the greatest social effect is in the problem's contribution to social disorganization. Some of the reasons for addiction can be found in the undesirable environment, economic deprivation, oppression of minorities, poor housing, overcrowding, and disorganized family life. But some of these things are also involved in the **results** of addiction because of the usual necessity for the addict to turn to crime to finance his habit. Another factor is that mental disturbance and psychological abnormalities are generally higher in this unstable situation. The result is crime and delinquency; personal tragedy; economic waste through high welfare costs, increased medical burdens, increased taxes for police, prisons, hospitals and other institutions; and all the other burdens of social disorder. There is a complex interaction of the **causes** of addiction and the **results** of addiction.

[2]Gardner, E. Clinton. "Narcotics and Other Addicting Drugs." *Concern*, Vol. 4, No. 11 (June 1, 1962), p. 11.
[3]Joint Committee, *op. cit.*, p. 46.

A further social question is that of addiction as a contaminating condition. In the eyes of many police and experts in the field, one addict contaminates another almost automatically. Another term used for this is "proselytism." It is true that addiction spreads through association, but why and how this is done varies widely. Many adolescents begin because of group pressure to try something new. Another widespread pattern is the pushing of dope to new persons in order to create an expanding market to which one can sell dope and finance one's own habit. However, this communicability is probably a result of a complex interaction of social forces rather than a compulsive urge to pass the habit on to someone else as some police officials contend. It does not follow that under changed social structures, the addict needs to be isolated to protect others.

The extent of narcotic addiction is very uncertain as statistics in this area are highly unreliable, as are any statistical trends as to the increase or decrease of addiction. Addiction and the sale of drugs is an underworld activity, and even those arrested do not give a true picture of the situation. The Bureau of Narcotics gives the estimate of 60,000 addicts in the U.S. and admits that this is a conservative guess. This does not include those receiving drugs legally. But another study in California had a more reliable guess of 20,000 illegal addicts in that state alone indicating that the national figure should be much higher. The only trends indicated are that since World War II the number of addicts has increased and that the most rapid increase has been among adolescents.

The most important social ramification of drug addiction is its high correlation with crime — especially crime against property. The narcotics racket brings in an estimated $400 million annually, and most of this money is raised illegally. Possession of the drug is a crime itself making every addict by definition a criminal. And of course, the traffic and sale of the drug is outlawed. It is an expensive habit and a profitable racket. A kilo of heroin purchased overseas at $300 is worth about $300,000 on the streets in America after it has been cut and re-cut by adding filler to it. The smuggling, preparation, and sale of narcotics is a lucrative business.

The addict becomes a criminal at two points. The first is when he obtains the drug. The second are the crimes of the theft, etc., into which he is almost forced to engage in order to raise the amount of money needed to sustain his habit. The average addict spends forty to seventy dollars a week or more on his habit, and the only things bringing in this high return are crimes against property and prostitution on the part of the female addict. It has been estimated that drug addicts account for about one out of every four crimes committed in the U.S.

The basic social question is whether drugs produce criminals or criminals often become drug addicts. Studies have been made and the results are uncertain. The police and others take one side and say that the addict is a criminal type and was usually a criminal before addiction. The Bureau of Narcotics claims that over three-fourths of the addicts have criminal records. But most of this may be accounted for by the bias of the bureau and the fact that these addicts-to-be live in the delinquency prone areas of slums and poverty. Many have been involved in minor violations before addiction.

Most of the studies support the view that addiction in itself does not produce criminality, but the result of addiction in forcing the addict to raise large sums of money would account for most of the crime. Several studies have shown that only about one-fourth of the addicts were criminally involved before addiction — a number not too

great for a slum-urban area. There is no evidence that the addict has any tendency to violent crimes except in the few cases where the inhibitions of psychopaths have been released through drugs, and the opiate effect on sexual desire rules out the addict-sex offender in most cases.

It appears that the latter group of studies make the better case: because addicts cannot obtain drugs legally, and because the habit is very expensive, the addict must turn to crime to finance and procure the drugs he needs to keep him going. It is on this basic question that most of the controversy rages.

Treatment and Solution: The Official View

The first school of thought is that held by the Bureau of Narcotics, most policemen and some of the more objective students of this problem. The basic principles of this school are as follows:

1. More stringent law enforcement. The Bureau of Narcotics has a high degree of success in arresting offenders, but they have not been successful in obliterating the traffic in drugs. They claim increased law enforcement and detection is a basic cornerstone in ending this traffic.

2. Coupled with the above is the necessity that the offender knows he will be punished, and the need for more severe penalties. Consequently, the sentences on both the federal and state level have been made longer and more severe in recent years. For receiving, concealing, buying or selling narcotics, the first offender will get 5 to 10 years from a federal court. If this is done with a minor, the sentence can be set at 10 years to life or even the death sentence. Suspended sentences and probation are not allowed. It is believed, then, that fear of punishment and the certainty of being caught will eliminate the problem.

3. The treatment of the addict in a prison-hospital pattern. The only cure, it is felt, is enforced abstinence followed by rehabilitation physically and sometimes socially, and control of the addict's life through probation after he has left the institution. It is this pattern that is followed in the two federal hospitals at Lexington, Ky., and Fort Worth, Tex. The large majority of the patients there are prisoner-patients. Of the total number taking the cure, 40% or more return to the drug habit from these institutions. Included in the treatment are withdrawal under medical supervision, psychotherapy, occupational therapy and rehabilitation, recreation, etc. The prisoner-patient is followed up somewhat through probation, but the voluntary patient (about one-third of the hospital population) has no follow-up. There is no segregation of patients and the young addict may learn as much about what will help him to become a more skillful addict as about that which will keep him from returning. While only about 40% return to the hospital, it is estimated that a much higher percentage return to the drug habit.

4. Permanent isolation of the incurable drug addict. It is felt that after so many tries, the addict should be permanently institutionalized to prevent him from becoming an addict again and removing him as a customer of the drug racket. In fact, former Commissioner Harry Anslinger of the Bureau of Narcotics has advocated that every addict undergo forced cures in a federl institution under sentence of 10 years, but be eligible for parole and employment in about one year. If addiction is repeated in that ten-year period, the addict would be institutionalized for life.

With some modification, this is the approach now being followed, and the improvements suggested by this school are mainly refinements upon these principles. Last July, Henry L. Gior-

dano was appointed to succeed the retiring Commissioner Anslinger, but he has publicly indicated that he stands one-hundred per cent with his former boss in taking this strong approach. The officials are most open to change in terms of methods within the institutions and in the parole follow-up, and it is here that the most enlightened thinking will get a hearing. But on dealing with the addict as a criminal, the lines get more rigid toward any change in attitude or method.

Treatment and Solution: The Medical-Legal-Humanitarian View

This school claims that the above methods are not working in most cases, and that the problems are getting worse **because** of the methods being used and not in spite of them. They pose the following criticisms of the above principles:

1. Stringent law enforcement has its place in controlling the drug traffic on both the international and national levels. The marketing of the drug without any control should be closely regulated. But outlawing the drug traffic, without providing the addict with some means of satisfying his desire (temporarily or permanently), only serves to drive up the price of illicit drugs making this a lucrative business. And because it is the need for the drug which causes the addict to turn to crime to finance his habit, strict law enforcement without some outlet for the addict only forces the addict toward crime in order to meet the high prices of the illegal traffic.

2. Strict punishment also misunderstands the process of addiction. Once the addict is hooked, he must satisfy his needs no matter what the consequences, and this fact coupled with the underground source of supply motivates the racketeer to continue his business in spite of heavy penalties. If the addict were not a criminal, and could deal with his problem in an open manner, the profit would be taken out of the drug business, and then strict law enforcement and heavy penalties for trafficking in the drug would make it almost non-existent.

Dr. Robert H. Felix, Director of the National Institute of Mental Health of the U.S. Dept. of Health, Education and Welfare said recently, "Addiction to narcotics . . . is a severe form of emotional disorder . . . But if a person acquires a criminal record solely because of his addiction, the problem of treating and curing him is made a great deal more difficult. This approach has made it virtually impossible for an addict to obtain help in overcoming his condition from a private physician. If a physician treats an addict by giving him gradually diminishing sustaining dosages of narcotcs, both the physician and the patient could technically be regarded as violating the law. And few doctors want to take that chance."[4]

3. This school also criticizes the present institutional pattern. They admit that forced withdrawal does bring temporary cures, but the basic problems of the addict are not solved. Most of the causes of his addiction remain, and he may learn even more skills that will help him become a "better" addict while in the institution. Parole is not adequate follow-up because once hooked, the threat of reincarceration will not prevent him from filling his deep need for drugs. This school grants that the hospitals such as Lexington and Fort Worth are better than prison, but they first of all cannot handle all the addicts in America. And while they may give the patient better care in withdrawal and provide him with some rehabilitation, they seem to have no better results in dealing with the patient in terms of his return to society than do the prisons. We simply do not know enough about addiction to produce lasting cures in most cases.

[4]*The New York Times,* July 9, 1962, p. 21.

4. They do not feel that incurable addicts need be isolated. In a society where the need for drugs to be dispensed through a criminal pattern is removed, the addict, it is felt, will not have the need to "contaminate" others with his habit, and he can perform adequately within society though perhaps not at his best.

The proponents of this school point to England and Europe in trying to find a workable alternative to our present system. In England, there appears to be no significant addiction problem, no organized illegal trafficking, etc. In England, addiction is seen as a medical problem, and the doctors have complete control over the distribution of drugs. This includes the administration of drugs to addicts as needed. Because drugs are available to the addict at points of his need, he need not turn to the black market. If he is not cured, his needs may be met indefinitely by the medical profession. In 1956, there were only 333 known incurables in all of England. It is granted that there may be more who get their drugs by private means such as doctor-addicts, but it is certain that the black market is not their source. The selling of drugs is highly regulated, and the police role is just as severe as it is in the U.S., but the addict is seen as a patient rather than a criminal. There is a rise in the use of marihuana (a non-addicting drug) among the growing number of British delinquents, but the addict problem seems to be under control though not solved. They are no closer to finding the cure than we are.

This school also points to the American Clinic plan of an earlier era. Starting about 1919, various U.S. cities operated narcotic clinics run by physicians. The addicts were treated as patients with drugs dispensed to them as needed. However, they did not deal with the moral and social aspects of the problem. Those who operated them did report that they made useful citizens of some addicts, reduced the crime problem, and a few cures were accomplished. They closed in 1921 after a small group of doctors in the A.M.A. pushed a move for confined treatment of addicts. This, coupled with increased pressure by law enforcement officials, closed the experiment. The officials charged that the black market continued and grew, that the number of addicts increased, that the clinics attracted criminals, and there were many other abuses. It is probable that the truth lies somewhere between. The clinics were a crude attempt that had many flaws, but they did go a long way in attacking the central reasons why addicts become criminals. It is very difficult to get the facts on this period of dealing with this problem.

Many solutions are put forth by the school advocating treatment of the addict as a patient rather than as a criminal. The most discussed, and the one being condemned by the Bureau of Narcotics, using both ethical and unethical means at times, is that put forth by the joint study committee of the American Medical Association and the American Bar Association. The main recommendations and conclusions are summed up as follows:[5]

> Its principal conclusions are two: that present methods of dealing with narcotic addiction and narcotic addicts raise questions which are urgently in need of study; and that the legal and medical professions, equally concerned, can most fruitfully pursue the subject in close cooperation through their respective associations . . .
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> The . . . report recommends additional research in five major areas:
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> 1. An experimental facility for the outpatient treatment of drug addicts, to explore the possibilities of dealing with at least some types of addicted persons in the community rather than in institutions.
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> 2. An extensive study of relapse and causative factors in drug addiction.

[5]Joint Committee, *op. cit.*, pp. 160-166.

3. The developmtnt of sound and authoritative techniques and programs for the prevention of drug addiction.
4. A critical evaluation of present legislation on narcotic drugs and drug addiction.
5. A study and analysis of the administration of present narcotic laws . . .

The report also came out with some general conclusions as a result of their study. They found that drug addiction has been increasing, especially in the slums. They point out that the response of the various governmental agencies has been to increase the penalties for violators which subjects both the peddler and the addict to prison sentences without the benefit of the probation and parole opportunities afforded other prisoners. Because they see the problem as having physical and psychological aspects, they state that it is the concern of medicine and public health as well as law enforcement and go on to question whether medicine is now in a position to take part in seeking solutions. They call for an objective study to find out if present policies and practices have interfered with good medical practice in this area.

Contrary to the picture of this report that has been painted by some officials, the report states ". . . emphatically that no acceptable evidence points to the indiscriminate distribution of narcotic drugs as a method of handling the problem of addiction."[6] They call for giving the addict the best help in losing his habit with special emphasis on helping him in the community after withdrawal. The report, however, does emphatically state that the criminal behavior of the addict is predominately a result of our present system which makes the drug traffic a profitable racket. They decry the hysteria by some officials over the problem and point out that while the problem is serious, it is small compared to others such as alcoholism. In other words, the report calls for a basic change in our philosophy of treating the addict and requesting more and better research into the nature of addiction and possible ways of meeting the problem.

Others would go further. They would call for clinics similar to the old clinics which would begin by registering the addict. After thorough examination and many safeguards against cheating are taken, the addict is given the drugs he needs to avoid the symptoms of withdrawal. After the patient is relieved of the tensions of constantly searching for drugs, positive treatment of his problem could begin through education, rehabilitation, employment, etc. The goal would be complete cures, but much remains to be done in this area to find adequate methods.

The official school has many criticisms of this progressive view. These include:

1. Legalized distribution is no different than legalizing prostitution, gambling, or any other vice. It may cut down on the immediate crime, but it opens up more problems just as bad.

2. It ". . . would elevate a most despicable trade to the avowed status of an honorable business . . ." (former Commissioner Anslinger).

3. Because of the tendency of the addict to need an increasing dosage, the habit cannot be controlled even under the best clinical conditions, and the addict is bound to cheat to get the extra dosage he feels he needs.

4. They deny the success of the British "system" saying that they have the same laws we do, they do not register all the addicts they have, Britain has a more stable culture, etc.

5. To supply an addict with drugs will only continue addiction. Forced abstinence is the only cure.

These and many other arguments are given against the clinic system, but the basic issue has not been met by the officials — that by providing drugs to the addict, the element of crime is removed. The officials merely deny this

and say that the crime still flourishes because the clinics cannot satisfy the increasing needs of the addict without handing out uncontrolled supplies of drugs. The thing that must be done, they say, is to quarantine the addict.

Conclusions

To understand the problem we must see it as two problems. First there is the problem of crime and addiction. It seems obvious that the more humanitarian school is right in seeing that addicts become criminals largely because of our present system and not in spite of it. To provide drugs under control to those in need, will remove all need of crime in the picture. The addict himself is sick and is not basically a criminal. The solution of the problem of crime, then, seems to be quite easy.

It appears that this viewpoint is having some effect. On June 25, 1962, the U.S. Supreme Court ruled a California law unconstitutional that made it a crime to be a drug addict in itself. In a 7 to 2 decision, Justice Potter Stewart said that narcotics addiction was an illness and called it "cruel and unusual punishment" to imprison "a person thus as a criminal." This decision has raised many questions and does not really settle the issue, but it does indicate that the progressive view is now getting a hearing.

But the total picture is not as easy as pictured above. To just hand out drugs willy-nilly may not be wise as the officials point out. They do have a good point in saying that the addict tends to increase his dosage, and the clinics may have a difficult time controlling the problem without allowing the criminal motive back in.

The second problem is that merely removing the criminal aspect of addiction will not solve the complex problems surrounding the cure of the addict.

It appears to me that while the more extreme clinic plan is basically sound, the A.M.A. - A.B.A. recommendations are the best ones for immediate strategy. They call for the basic change needed in our philosophy: to see the addict as a patient rather than a criminal. Then they go on to ask for a greatly increased program of experimentation and research into all aspects of the problem. We do need to know more before we begin any grand schemes to attack addiction.

Our program of strict law enforcement should go on as it has been fairly successful in regulating the traffic to some degree. But a side issue here is the danger inherent in the continuing demands by the Narcotics Bureau for the suspension of the civil liberties laws when they carry out their work. We must be on guard at this point.

We must change, as called for in the report, to see the addict as a patient and to seek new and better ways of treating him. Compulsory treatment has a lot of sound arguments on its side, but this too needs more study. Our most immediate need is to seek the best way of removing addiction from the realm of the criminal world. Just because we see that the majority of addicts cannot be cured at present does not justify sanctioning our criminal producing system. After we re-remove this element, perhaps our progress toward the goal of curing the addict will be more rapid.

The Role of the Church

Our Christian faith and the structure of the church have much to offer in moving toward a solution of the narcotics problem.

First, our faith provides for us the concern for individuals as persons with problems. The context of Christianity allows us to come to the problem with a concern for healing and redemption of the individual rather than with a punitive drive to eradicate "those evil fiends." We need to seek out the best means for helping the individual, and to seek to find those means which

would make the structures of society itself, as they relate to this problem, a better and more workable structure in terms of our principles of love and justice.

Secondly, if we take seriously the idea that the church is a redeeming fellowship within the context of our society, then we must seek better ways for our churches to play a positive role in the search for answers. All too often our church people have accepted the punitive attitudes held by some officials. It is not the job of the church to carry on a crusade against drug addiction, but the church can provide some positive contributions.

The church can be a vehicle for accurate information so that its members may approach the problem with intelligence. It can do much of the education of youth that is necessary so that they will understand addiction and be able to meet the problem should it ever touch their lives. But the adults in our churches also need accurate information as they are the decision makers that support or attempt to change our present inadequate system. An aroused and informed public can do much to support those public authorities who are working for workable solutions. There are many enlightened officials, perhaps more than I may have indicated in this article, but they need a wider public support before they can advance in the face of strong opposition by a small and powerful group of officials now in control.

The church might even participate in some of the direct research and action. For example, the East Harlem Protestant Parish has a clinic that is 17 years old to help adults "kick the habit." This clinic does not dispense drugs, but tries to help with encouragement and advice as well as practical help in meeting the problems of life. Not all churches can do this, in fact most of our churches are not in areas where the problem exists. But the total church could support some cooperative efforts in research and experimentation, working with other community organizations, in order to meet head-on all the social and individual aspects of the problem.

And finally the church could do better in being the redemptive fellowship that it claims to be. Why can't the church accept the addict as a person with a problem rather than a criminal? If the church could take in those who are honestly seeking help and provide them with young people's groups and other social structures that are wholesome, normal, and supportive; by providing a fellowship of warmth, concern, and supportive counsel; the addict who has "kicked the habit" may be able to find his cure a permanent one. A few churches have done this, but the church generally stands under judgment because of the greater success of fellowships such as Narcotics Anonymous.

The drug addiction problem is growing, and it is evident that what we are doing now is not the answer and is probably aggravating the problem. Easy answers are not available, but we must start to find them.

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[6] *Ibid.*