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The Traffic in Narcotics

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GENERAL

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An interview with the Hon. Harry J. Anslinger United States Commissioner of Narcotics

The Honourable Harry J. Anslinger, Federal Commissioner of Narcotics for the United States of America, has just published, in collaboration with William F. Tompkins, United States attorney for the district of New Jersey, a book entitled The Traffic in Narcotics (Funk and Wagnalls Co., New York, 1953).

The experience and wide knowledge of the question that Mr. Anslinger has brought to this work make this book a very important one for all those concerned with the problem, and the editors of the Bulletin on Narcotics considered that the following interview with him, dealing with the most important statements in the book, would be of general interest.

Q. When you chose the title for your book, *The Traffic in Narcotics*, am I right to assume that you had in mind primarily the illicit trade?

A. Not exactly, since I deal with the licit trade as well, but unfortunately the illegal aspect of the traffic is by far the most troublesome, since addicts are almost in all cases supplied by it.

Q. Do you think drug addiction is a specific mark of contemporary life?

A. By no means: for centuries the poppy has been the instrument of unprincipled men who by it satisfied their lust for wealth and power, of nations who used it for amoral reasons and as a potent weapon of aggression.

The character of drug addiction being different in different regions of the world, we do not have adequate, up-to-date and comparable information regarding its extent.

The international community organized the struggle against the narcotics evil by concluding a series of international treaties in this field and by creating organizations entrusted with the application of these instruments: a policy-making body, which was called the Advisory Committee of the League of Nations (now the Commission on Narcotic Drugs of the Social and Economic Council of the United Nations); a body in charge of the control of international statistics relating to legitimate manufacturing of, trade in, and consumption of narcotics, the Permanent Central Opium Board; a body in charge of estimating the world's legitimate needs in narcotics, the Supervisory Body.

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Q. How effective were the opium conventions?

A. The machinery established by the Supervisory Body emerged from its initial trial in 1933 with considerable success. Estimates were received that year for 45 countries (including 14 countries which had not ratified the Convention) and for 83 colonies, protectorates and territories. The Supervisory Body was called upon to provide estimates for 23 countries and 31 colonies for which no estimates had been furnished. For 1952, estimates were furnished by 73 governments and 78 territories, and the Supervisory Body was called upon to provide estimates for only 10 countries and 6 territories.

The effectiveness of the Committee is attested to by the fact that in its first year of working it succeeded in reducing the total amount of morphine required for all purposes (in 1934) by more than three tons.

But the main international body was the Advisory Committee.

Q. Do you think the Advisory Committee really succeeded in checking the illicit trade?

A. As the result of the Opium Advisory Committee's turning the pitiless spotlight of the world press on specific narcotic conditions from time to time, it was able to drive the illicit traffic from France, Switzerland, Holland, Bulgaria and Yugoslavia. It repeatedly exposed the manner in which loose controls over manufacture, and lack of effective laws had encouraged the building up of large scale illicit trafficking in these countries.

Q. I understand that a new single convention is in the making, in addition to the existing eight international agreements on narcotics. In your view what should be the purpose of this new single convention?

A. The object of the proposed unification is not only to combine the eight international agreements on the subject, but also to revise and strengthen these agreements, closing loopholes and rejecting obsolete provisions. It is obviously most desirable to revise these international agreements, one of which dates back to 1912, and to incorporate them if possible into a single agreement which will provide reasonably effective control in these main fields: the production of opium, coca leaves and cannabis; the manufacture of the dangerous or potentially dangerous products of these substances as well as of synthetic substitutes for them; and the distribution of such raw material and of the manufactured products or synthetic substitutes.

Q. From 1909, when the United States convened the Shanghai Conference, the United States has always taken a considerable part in the international struggle. A good example of this activity is the effort to abolish the opium monopolies in the Far East. Apart from its general humanitarian purpose, what was the immediate practical reason for the efforts of the United States during the Second World War towards abolishing the opium monopolies, and what was the result of this effort?

A. From the standpoint of the health and safety of the men of the armed forces of the United States, the government was convinced that it was imperative, immediately upon the occupation by the United States forces of a part or the whole of any one of the Japanese-occupied territories, to seize all drugs intended for other than medical and scientific purposes. American expeditionary forces under American command were therefore instructed to close existing opium monopolies, opium shops and dens. That was the immediate problems.

As a result of these discussions the United States Government on 21 September 1942 addressed an *aidemémoire* to the United Kingdom, the Netherlands and other interested, governments on this subject. On 10 November 1943, the United Kingdom and Netherlands Governments announced their intentions to abolish the legalized sale of opium in their Far Eastern territories, and similar action was later taken by the Governments of France and Portugal. Opium smoking has now been declared illegal in all parts of the world except in Thailand.

Q. In order to be able to participate usefully in the international struggle, it seems that a country should first establish its own control: what are the principal measures for the control of narcotics in the United States?

A. The three principal federal statutes controlling the substances under discussion are the Harrison Narcotic Law, as amended, now incorporated in the Internal Revenue Code; the Marihuana Tax Act, as amended, also incorporated in the Internal Revenue Code; and the Act of May 26th 1922, as amended, known as the Narcotic Drugs Import and Export Act.

Sales or transfers of narcotic drugs are limited generally to those made pursuant to official order forms obtainable, in blank, by registrants, from the Director of Internal Revenue. Exception from the order form requirement is made in favour of dispensing to a patient by a qualified practitioner

in the course of his professional practice only, provided, however, that such physician, dentist or veterinary surgeon shall keep a record of all such drugs dispensed or distributed. The record must include the amount dispensed, the date, the name and address of the patient to whom the drugs are dispensed, except in cases where the drugs are dispensed by the physician in the course of personal attendance. Another important exception from the requirement of the Act is found in the case of a sale by a druggist to or for a patient, pursuant to a lawful written prescription issued by a qualified physician, dentist or veterinary surgeon. Penalties are provided for violation of the Act and the Secretary of the Treasury is given the power to make, prescribe and publish all the needed rules and regulations for carrying the provisions of this Act into effect. This Act is designed to direct the manufacture and distribution of narcotic drugs through medical channels to consumption use for medical or scientific purposes only.

Q. What are the main provisions of the Narcotic Drugs Import and Export Act?

A. This Act authorizes the importation only of such quantities of opium and coca leaves as the Commissioner of Narcotics shall find to be necessary to provide for medical and scientific needs under such regulations as the Commissioner shall prescribe. Importation of any form of narcotic drugs except such limited quantities of crude opium and coca leaves for medical and scientific uses is prohibited. The importation of smoking opium or opium prepared for smoking is specifically prohibited, and possession of such opium is made prima facie evidence of an offense. The aim of this latter section is to stamp out the use of narcotics in this country except for legitimate medical purposes. While numerous attacks have been made on the validity of this section, the courts have held that under the power accorded it by the Constitution, Congress had the power to regulate foreign commerce to create the presumption contained therein. The Act also permits exportation of manufactured drugs and preparations under a rigid system of control designed to assure their use for medical needs only in the country of destination.

Q. What are the main provisions in the United States concerning the dispensing of drugs by physicians and druggists?

A. A physician who intends to practice medicine and to administer or dispense narcotic drugs in the course of such practice must apply for registration under the Harrison Law with the Director of Internal Revenue of the district in which he proposes to practice, and must pay the appropriate occupational tax for the fiscal year applicable. Before being entitled to such registration, however, he must be lawfully entitled under the laws of the state or territory or district wherein he intends to practice, to distribute, dispense, give away or administer narcotic drugs to patients upon whom he, in the course of his professional practice, is in attendance [26 U.S.C. 3220]. In the case of a medical practitioner, this requirement usually means that the applicant is a physician who holds an unrevoked and unrestricted license to practice medicine in the particular state, territory or district.

The right to register and pay tax under the federal statute depends on the right to dispense under the state laws.

The provisions of the law are substantially the same for a druggist.

Q. The agency in charge of the implementation of these Acts is the Bureau of Narcotics. What are its main duties ?

A. The duties of the Bureau include the investigation, detection, and prevention of violations of the federal narcotic laws (including the federal Marihuana Law and the Opium Poppy Control Act of 1942), the determination of quantities of crude opium and coca leaves to be imported into the United States for medical and legitimate uses, and the issuance of permits to import the crude narcotic drugs and to export drugs and preparations manufactured there-from under the law and regulations. An annual report is made to Congress which also serves the purpose of the report in behalf of the Government for transmittal through the State Department to the nations signatory to the International Drug Conventions of 1912 and 1931.

Q. Is it true that your Bureau has the possibility of buying information concerning the illicit traffic?

A. By special statute approved 3 July 1930, the Commissioner of Narcotics is authorized and empowered to pay to any person from funds appropriated for the enforcement of the federal narcotic laws of the United States, for information concerning a violation of any narcotic law resulting in a seizure of contraband narcotics, such sum as he may deem appropriate.

Q. What has been in your opinion the general trend of narcotic abuse in the last generation?

A. The federal narcotic laws and the state narcotic laws have been in force for only a generation. Throughout that period and until just recently there had been a steady, substantial decline in addiction. It coincided with the enforcement of penal narcotic laws. There was a deviation from a straight decline in a rather sharp upsurge after the First World War, but that soon subsided. In the early 1920's, heroin and morphine were available at \$25 to \$50 an ounce. A few unscrupulous doctors were writing prescriptions for narcotics in large amounts. Drugs were smuggled into the country in trunk lots. It was common for addicts to have tremendous habits: 5, 10, 20, or even 50 grains of morphine a day! Today, the unscrupulous doctor has almost disappeared. The occasional cheater dares to prescribe a few grains only instead of ounces. Wholesale diversions are non-existent except for an occasional bona-fide robbery or burglary. Smuggling is in small amounts that can be concealed on the person.

Q. The laws on narcotics being somewhat complicated, the physician and druggist find it probably difficult to observe them; can you indicate a few rules which, in your opinion, should help in the interpretation of the narcotics statutes?

A. A physician could avoid the pitfalls attendant to criminal and civil liability if the following fundamental rules were observed:

1. Secure a complete history of the ailment;
2. Make a complete and thorough physical examination in every case;

3. Ascertain whether the illness requires narcotics and good medical practice demands their prescription;
4. Use non-habit-forming drugs instead of opiates wherever possible;
5. Beware of strangers and itinerant patients who suggest their need for drugs;
6. Remember always that improper and prolonged dosages can cause an individual to become an addict;
7. Do not write a prescription for office use. That supply should be secured on a drug order form.

Druggists should consider the following suggestions:

1. Refuse to compound an improperly prepared prescription;
2. Make no delivery of a telephone prescription without receiving a properly prepared prescription before delivery of the narcotic is made;
3. Never sell a narcotic drug except upon prescription;
4. Remember that narcotic prescriptions may not be refilled;
5. Be familiar with the quantities a customer is using; exorbitant quantities over a long period should warrant close scrutiny.

Q. The public is sometimes under the impression that drug addicts are unfortunates who have been slaves to an evil habit which anyone is liable to contract. Is this correct?

A. Too infrequently are we told that the chances of a complete cure are not good, that those addicted a relatively short time represent most of those cured, and that relapse is frequent. Too infrequently are we advised that we are in the main not dealing with average citizens who have suddenly been smitten by drug addiction, but in fact with people who had unpleasant and troublesome tendencies before drug addiction was superimposed. And too infrequently are we informed that many cases warrant strong corrective action because of some basic disturbance which drugs have awakened, or simply because of prior antisocial behaviour. A spot check of any police record bureau will disclose the fact that many addicts were criminal offenders long before taking on the drug habit. Make no mistake about it - we are not dealing with something hospitalization alone will cure but a dreaded scourge that penetrates infinitely deeper and requires a much greater effort to uproot. And in too many cases, we are confronted with some inherently bad patients.

Q. Could you give a figure, however rough, of the estimated number of drug addicts in the United States from 1877 up to now?

A. Three-quarters of a century ago, narcotics addiction in the United States was almost eight times as prevalent as it is today. In 1877, the estimated number of narcotic users was 1 in every 400 of the population.

When the Harrison Act was passed in 1914, there were perhaps 150,000 to 200,000 narcotic addicts in the United States, or about 1 in every 460. Remedial legislation had the effect of scaling down addiction until the First World War, when only 1 man in 1,500 drafted was found to be a drug addict. There was a deviation from a straight decline in a rather sharp upsurge after the First World War, and in 1924 it was estimated by the United States Public Health Service that there was 1 addict in every 1,000 of the population.

As the result of vigorous enforcement of the federal narcotic laws, the figure dropped to 1 man in 10,000 in the Second World War. When that war ended, addiction was probably at the irreducible minimum. A temporary upswing in addiction occurred again in the post-war period, as predicted by the Federal Bureau of Narcotics.

Q. How should the addict be treated?

A. Proper treatment dictates that the drugs be withdrawn humanely and gradually from the patient, followed by rehabilitative and psychiatric treatment. Generally the best plan for withdrawal involves the substitution of methadon for whatever drug the addict has been using, followed by a reduction of the dosage of methadon over a period of approximately ten days.

After withdrawal has been accomplished, any chance of cure requires a prolonged period of institutional rehabilitation under closest surveillance. The individual should be enabled to engage in useful work each day and occupational therapy should be geared to bring out and implement any talents or skills which are present. It is important that all patients, including those with chronic diseases, be required to participate in some type of useful endeavour. Recreational facilities, such as movies, athletics, games, reading rooms and music, should also be provided.

Psychotherapy, of great importance in the effort to avoid relapse, must be adequate. The treatment parallels that given to non-addicted persons suffering from psychoneuroses and other character disorders with a view to obtaining as high a degree of mental and emotional stabilization as possible. Unfortunately, adequate personnel is lacking to care for all those who require psychotherapy.

Q. What principles would you recommend in any antinarcotics campaign?

A. Strong laws, good enforcement, stiff sentences and a proper hospitalization programme are the necessary foundations upon which any successful programme must be predicated. These, plus an alert and determined public, will go a long way towards blotting out the problem. Probably the greatest reason for an increase in drug addiction has been the failure on the part of the legislators, of police, and of other officials to observe these important fundamentals. Most important, good results can be attained by perfecting the framework of the present federal and state laws, which are fundamentally sound.

Q. Considering the divergences in the approach to the problem of the addict, what measures would you suggest for the application of a law, for instance, of a state law, against narcotic offenders?

A. To make a law - such as New Jersey's - function, and to prevent any abuses, the following principles must be observed:

1. Addict violators who are placed on probation must be given a probationary period of at least five years. Control of the addict during the period of his treatment and rehabilitation is imperative;
2. The addict violator shall be required, as a condition of his probation, to submit to hospital treatment and to remain hospitalized until released by competent medical authority;
3. The addict violator shall be required, as a condition of his probation after discharge from the institution, to submit to a thorough examination each month by a public health doctor for the remainder of his probationary period. This is the only accurate way to determine whether or not an individual has commenced taking drugs again;
4. Probation authorities should be required to keep a very close check on drug violators after their discharge from the institution and to submit monthly reports to the court by which the individuals were sentenced;
5. A comprehensive program of follow-up care should be set up either by the state or local community with the co-operation of judges, doctors, probation and parole authorities and social welfare agencies. This is of vital importance since the lack of follow-up care has been the greatest cause of recidivism;
6. Maximum sentences should be used against the professional criminal with no probation, parole, or suspension of sentence being granted in any case. The minimum sentence for the narcotic peddler should be five years. To escape the punishment he may lead law enforcement officers to the source of supply;
7. Bargain pleas made with the intent to lighten sentences should not be accepted by a prosecuting attorney;
8. Every case, no matter how small the amount of narcotics involved may be, shall be presented to the Grand Jury and vigorously prosecuted;
9. In any case involving a sale of narcotic drugs by an adult to a minor, the offender will receive the maximum sentence which the particular state or federal law allows.



Q. Do you think that teen-age addiction is a new and ominous phenomenon?

A. The addiction of persons in their late teens, loosely referred to as teen-age addiction, is not novel in this country. Heroin was used by this age group in the early 1900's. It was one of the developments which brought about the enactment of the Harrison Narcotic Law in 1914 and later on, other federal and state laws outlawing the narcotic traffic.

The following is cited from a report of a special committee appointed by the Secretary of the Treasury in 1919: "Most of the heroin addicts are comparatively young, a portion of them being

boys and girls under the age of twenty. This is also true of cocaine addicts." But after the outbreak following the First World War, the tendency was for fewer young people to become addicted. The new addicts were in a slightly older category and the youthful addict became an exception and a curiosity.

On the basis of First World War experience, the Bureau of Narcotics feared and predicted some rise in addiction after the Second World War, and these forebodings proved to be well justified. An increase in addiction was noted around 1948, first as a trickle and then as a small stream. By 1952, admissions to federal narcotic hospitals and other factors showed that the crest of that increase had been passed. However, the situation remains a dangerous one, the correction of which is a challenge to the best efforts of everyone concerned.

It is the considered judgment of officials in the Bureau of Narcotics that this epidemic of narcotic addiction among younger people is primarily an extension of a wide-spread surge of juvenile delinquency. While it cannot be completely dismissed or completely described as a big-city problem, that, practically speaking, is the situation. Also, it is a problem confined for the most part to those areas where many factors contribute to delinquency and lawlessness among the affected youth.

Q. What do you think of the clinic plan in the cure of drug addiction?

A. The clinic plan recently advocated by a small minority group in one section of the country would radically change the present plan of enforcement and revert to dispensing narcotic drugs to drug addicts for the purpose of maintaining addiction. 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. The proponents of the plan claim that the dope peddler would thus be put out of business.



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

The answer to the problem is not, therefore, to accept narcotic drug addiction as a necessary evil and calmly proceed to ration with a daily supply each and every person who applies for the ration. It should rather be the provision by the states of facilities for scientific treatment of these unfortunates, looking toward a cure, coupled with vigorous and unremitting efforts toward elimination of improper sources of supply so as to facilitate complete rehabilitation of the reclaimed addict and prevent the addition of recruits to the ranks of these unfortunates. By scientific treatment is meant that professional treatment which includes confinement or restraint upon the addict to ensure that no surreptitious source of supply is available to him that would defeat the purpose of the attending physician.

Q. Would you say then that the addict cannot be cured?

A. Yes and no, depending on individual circumstances. Young people and those addicted a short time are the best prospects. There is at Lexington the finest hospital of its kind in the world. Many experts will cite an over-all rate of 25 per cent cures; cynics off the record will claim that it actually is no more than 2 per cent. At the best, these are harsh statistics. The bright side, however, is the Lexington story. From 1935 to 1952, 18,000 addicts were admitted for treatment. Of these, 64 per cent never returned for treatment, 21 per cent returned a second time, 6 per cent a third time, and 9 per cent four or more times.

One final word. Those who fight drug addiction are fighting uphill with the odds very much against them. There is no sure cure, no complete knowledge, and the chances of winning are definitely not too good. It may very well be the beginning of the end-a short and horrible existence. The best cure for addiction? Never let it happen!

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