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SECTION II

DRUG ADDICTS, USA

The Czar Nobody Knows

By WILLIAM DUFTY and FERN MARJA

Harry Jacob Anslinger came to Washington from Altoona, Pa., when this century was in its teens. At that time, millions of Americans shared the vision that ancient evils and urges, like whisky, "white slavery" and opium dreams, would wither away under the impact of federal prohibitions.

Forty years later, one noble experiment is dead by repeal; the Mann Act survives as a trap for unwary call girls. The vision has withered and dimmed but Anslinger is still there.

The one-time Assistant Commissioner of Prohibition regards his 30-year reign at the Federal Bureau of Narcotics as a rare triumph of temporal power over social evil.

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Medical research, Supreme Court decisions, experience of other nations, the crescendo of criticism at home—all these he regards as killers of the dream.

The repressive police policies of his bureau are grounded in two propositions:

¶Medical treatment of narcotic addicts by private physicians is illegal. This, to him, is a matter of morals.

¶State-sponsored medical treatment for narcotic addicts—compulsory where possible, as for instance with residents of voteless District of Columbia—is the answer. It works. This, for him, is an article of faith.

Anslinger proposes extension of compulsory government treatment to broad new areas of the addict population. When these reporters suggested that the rate of success with patients at Lexington federal hospital was unknown or very minute, this was a fact Anslinger refused to face.

"They have checked out their rate of cures at 17 per cent," he insisted. "I think that's incredibly low."

We suggested that compulsory psychiatric treatment might be a contradiction in terms which doesn't work.

"Oh, no," said Anslinger blandly. "We think Lexington is doing a better job than it knows."

The 17% figure, like most of his statistical crutches, collapses under scrutiny. Dr. Kenneth Chapman, former medical chief at Lexington and now consultant to the Public Health Service, told us: "That figure Anslinger likes. You can extrapolate it until you're blue in the face. The survey was done in a desultory fashion about 18 years ago. We didn't even publish it because we are not very proud of it. It was based on answers to letters and there was no way to check their veracity."

The present medical chief at Lexington told us: "That 17 per cent figure grates on me."

Anslinger's belief that a physician cannot treat an addict in private practice is uncompromising.

"People leave this problem to the federal government by default," he lamented to us. "Why just take care of addicts? Why not alcoholics and cancer victims?"

"There are no private hospitals, clinics or doctors

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NARCOTICS COMMISSIONER ANSLINGER

they would not only find they also have a provision for the individual who appears not to be able to lead a socially productive life when he is off narcotics. How often it is used, I don't know."

In effect, the British approach centers on the physician, the American on the police.

Dr. Jeffrey Bishop of London makes just this point in his report in Dr. Marie Nyswander's recent book, "The Drug Addict as a Patient," published by Grune and Stratton. Britain's Dangerous Drugs Act of 1920, the equivalent of our Harrison Act, Bishop writes, "places the responsibility for the management and treatment of the addict in the hands of the medical profession."

He underlines the fact that to be a drug addict in England "has never been and is not now illegal," and adds: "The addict is committing an offense only if drugs found in his possession have been unlawfully obtained. He is regarded as a sick person in need of medical care and not as a criminal to be hounded by the police."

Bishop then blueprints the basis of the British plan:

"Doctors may only supply or prescribe dangerous drugs for their patients when a real medical need for the drug exists; but the Home Office recognizes that to supply an addict with minimal maintenance doses does, in some cases, constitute a medical need."

This is the heart of the matter. The English physician notes in conclusion:

"The number of addicts known to the Home Office (less than 400) represents, for all practical purposes, the actual number of addicts in the country and there is no evidence of organized traffic. Drug addiction presents no real problem in the United Kingdom."

Narcotics, including heroin and morphine, are legally provided by private physicians for registered British addicts under the National Health Service Act, which compensates doctors for such treatment.

The British Way

Obviously this setup removes the profit from black market operations in drugs. Compared to the astronomical number of arrests made in the U. S. every year involving junkies and pushers, England last year had a total of 11 addicts sent to prison for any offense whatsoever.

(Confronted with this figure, Anslinger, unmoved, said: "Eleven convictions are 11 convictions.")

The polar differences in the application of the twin American and British drug laws are dramatized in the following incident:

An American entertainer, known by the British police to be a heroin user, was performing at the London Palladium in 1954. The entertainer consulted a London physician, giving a false identity, and received a prescription for some heroin.

The entertainer was quietly arrested, convicted and deported, without any publicity. The contrast between the British operation and our own is underlined by the charge against him: giving false information to a doctor.

Dr. Alfred Lindesmith, an eminent American sociologist who is an admirer of the British form of narcotics control and is consequently viewed by Anslinger as a member of the disloyal opposition, asked the London authorities what might have happened if the entertainer had given the doctor his right name.

"In that case," they told him, "nothing would have happened. There would have been no violation of the law."

It is this system that is attracting the attention and speculation of American experts. Some of them want to adopt it here; some wonder if the British approach

Rev. C. Kilmer Myers
An oasis on hallowed ground.

avoids that experimenting with the new and failing is preferable to adhering to a program that has consistently failed for 40 years.

It is less morality than humanity that these crusaders wish to invoke. They recognize that there can be no simple solution to so complex a problem. They realize that too little is known still about the addict and his drugs to arrive at an ideal solution.

But they have this in common: they see the addict as a troubled human being; they want to help him, not judge him. It is as simple as that.

Chief Magistrate Murtagh says:

"Some 40 years of blunders have so aggravated and complicated the situation that it is unfair to ask us for an alternative solution.

"Basically, my attitude is that we should get to the point where the British are—where the doctor is not in fear of being accused of being called a criminal if he treats the addict. We should ask ourselves whether our government approach is not sparking drug addiction instead of curing it."

'It's Worth a Trial'

Corrections Commissioner Kross, who is required to house self-committed addicts in the city jails and is performing a herculean task in trying to carry out this assignment against grotesque odds, says:

"I personally feel no individual should be sent to jail for drug addiction. I certainly don't feel self-committed addicts are criminals. I think Mr. Anslinger hasn't moved in his thinking since 1914. I think the application of the Harrison Act should be changed.

"I won't pretend I have the answer. But I believe the British system is worth a trial here. I can't vouch for the fact that it would work here. But I *can* vouch for the fact that the system we have now is *not* working here."

Sen. Javits, one of the rare politicians who is informed on drug addiction, abruptly changed his course:

"I made a speech before the Association of Attorneys General in 1956 in which I broke with the past and adopted the Nyswander thesis that drug addicts are sick people. I believe in a threefold attack.

"First, treatment facilities should be made available to these people so that they can have clinical attention.

"Second, we must have adequate research. This is so devastating an illness that we don't know how to cope with it at present.

"Third, we must have a follow-up program, which may take years. This is a very, very expensive illness.

"I advocate a strictly controlled experiment with the British plan. I don't advocate that the British system be adopted here until we try a controlled project."

The American Medical Assn., surely one of the least radical organizations in the country, recommends in the current report on drug addiction by its Council on Mental Health revision of the organization's 1924 resolution condemning "any system of treatment that puts opiates in the hands of addicts for self-administration."

Highlighted in the final sentence of the AMA statement is the significant declaration that "consideration should be given to broadening the resolution to include a plan indorsing regulations somewhat similar to those currently in force in England."

The Physician as Crutch

Even more comprehensive is the report just published by a study group of the World Health Organization, which states:

"It cannot be too strongly emphasized that the first principle of the treatment of drug addicts is that they should be looked upon as patients, that is to say, treated medically and not punitively."

The WHO document cites as the goal of treatment a good adjustment without drugs, but it does not hedge on the issue that most provokes Anslinger's ire. Challenging the Commissioner's dictum that supplying an addict with drugs is "mere gratification" of his habit and therefore wrong, the study group asserts:

"There are well-recognized obvious medical conditions, such as severe chronic or terminal illnesses, where continued administration of drugs is indicated. In addition, experience with the problems of addiction in several countries and newer knowledge of the psychology of addiction leads the medical profession to believe that in exceptional cases it is within the limits of good medical practice to administer drugs over continuing periods of time."

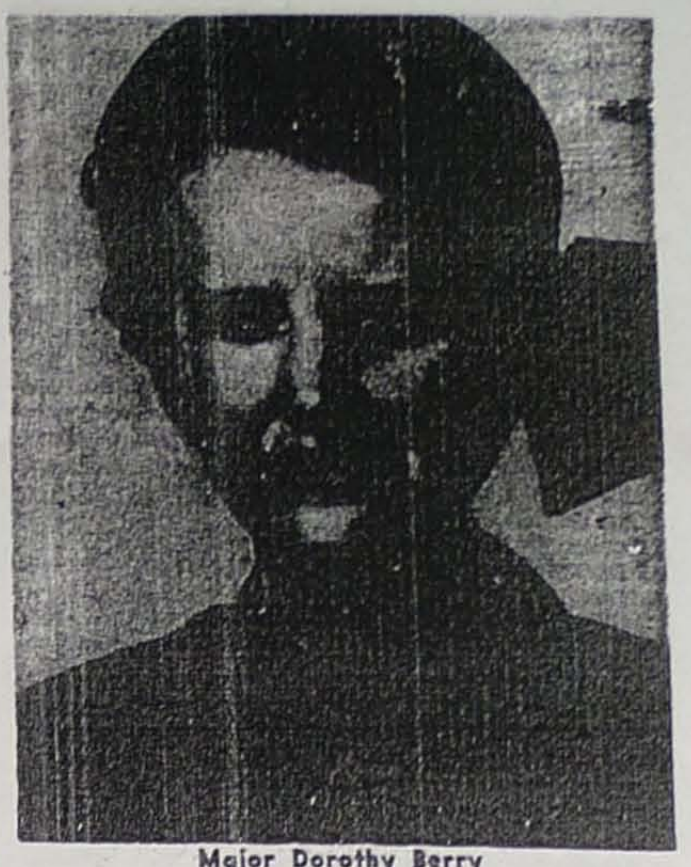
But perhaps the most revolutionary point the international body makes is that the addict patient should, so far as possible, be allowed to make—or feel that he has made—a free decision to obtain treatment.

This conclusion, which contradicts all federal procedures and objectives in the U. S., was repeatedly presented to these reporters by the most successful of the therapists now treating narcotics users.

A distinguished doctor in this city, who prefers to remain anonymous rather than risk a head-on collision with the Narcotics Squad, said:

"You cannot treat the addict by force. He has to have his own motivation to get cured. So I let him take his drugs. I don't stop him. You, the physician, are his addiction for a while.

"This is the basis of all psychotherapy. For a time, the patient uses you as his crutch. Then you can take his other crutch, the drug, away from him—that is, he reaches the point where he can give up his addiction himself with your encouragement."



Major Dorothy Berry
Anonymity has its perils.

All of this focuses attention on the physician, whose spirit is willing but whose flesh is too weak to oppose Anslinger's power and glory.

Dr. Nyswander, who spent a year on the staff of the U. S. Public Health Hospital at Lexington, Ky., and then moved on from there in her thinking ("I don't understand what has happened to her," said Anslinger, who is often baffled by the obvious. "She was an Anslinger man when she was at Lexington—now she thinks I have horns"), put it in blunt terms:

"Let the doctors think this through medically and decide once and for all: Is it ethical or unethical for a physician to give drugs to an addict? Once this is decided, some other things will begin to fall into place."

(Some measure of the average doctor's enthusiasm for this controversy can be gained from the sales of Dr. Nyswander's book; less than 500 copies have been sold.)

For a year Dr. Nyswander conducted a telling experiment with addicts as out-patients. The project was sponsored by the Postgraduate Center for Psychotherapy and was similar in intent to Chicago's St. Mark's Clinic.

With 30 psychoanalytically trained psychotherapists, Dr. Nyswander studied the accessibility of narcotic addicts to voluntary treatment outside a hospital setting. Of the 64 addicts who were interviewed by this staff, 13 remained in treatment at the end of a year. Ten had ceased to use drugs, two had decreased their habit and one took drugs only occasionally.

"It has been demonstrated," the Nyswander group reported, "that some drug addicts will voluntarily present themselves for psychotherapy and that they do not seem to present untoward hazards. *They may be treated on an ambulatory basis while still addicted."*

Of Anslinger's compulsory treatment-or-nothing ultimatum, Dr. Nyswander comments: "It shows ignorance of the true nature of the drug addict and addiction. The only time addicts cause trouble is when they're in places against their will."

But, so far, constructive thinking on the drug addiction problem falls under the heading of things to come—maybe. For things here and now, the outlook is foreboding.

The pessimism with which the addicts themselves react to the unrelieved darkness in which they move is illustrated by an experience Father Myers had with an unfinished film shot in the streets of the Lower East Side by youngsters at his Episcopal mission.

The film-makers needed no technical advice on addiction. According to Father Myers, the director had a habit and the teen-age cast was liberally sprinkled with heroin mainliners. ("The Judgment of God is upon those parishes which are not oases . . . ," Father Myers has written.)

There was little argument about early story points. How to end the production, however, precipitated a conference more bitter and heated than the fight for control of MGM. Some of the youngsters insisted on an upbeat finish; others held out for a hopeless fade-out after the adolescent addict gets killed by a cop.

A vote formalized the deadlock. Four (non-junkies) voted for hope. Four (junkies) voted for death.

The rector proposed ending the movie with a question mark.

(Last of a Series)

DRUG ADDICTS, USA

By FERN MARJA and WILLIAM DUFTY

The kids had the toughness and the cynicism that mean survival in the lower depths, and their gutter knowledge carried the stamp of authenticity.

They met every week with a psychologist from the Board of Education's Bureau of Child Guidance, Mrs. Edna Mann, who was trying to prevent their armored defenses from rolling them into the area of delinquency.

This particular week, at the suggestion of NYU researchers, she asked the group to discuss drug addiction. The kids were not addicts, but they came from neighborhoods where drug addiction is a fact of life.

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Why, Mrs. Mann asked them, do juveniles take drugs?

"Because they have a lot of trouble," one boy said. "They can't get along with people."

"Anybody could get on it," volunteered another. "Something happens home. You don't care any more. You lose your girl friend. Before you know it, you are on the kick."

What about marijuana?

"I did it—it is not habit-forming."

Another boy confirmed this: "It can't kill you. I did it, too. You don't go crazy from reefers."

The group comedian burst into song, "Sweet marijuana, go too high, touch the sky . . ." But the kids were involved in the discussion now, moving with it, and during that session and the next they came up with the following concepts:

ON TREATING ADDICTS:

"They should be talked to."

"You got to understand them, bear with them, try to settle their problems. To determine why they take it—that's the point. Maybe you can give them another habit, like chewing gum or going to the movies."

"Talk to them friendly."

ON THE LURE OF DRUGS:

"You feel fine, happy, lively, itch all over."

"When they get that dope in them, they don't know what they're doing. They get a notion they can do whatever they want. Like a king with power over all his land. In a way, they do have power. Not real power. They think they can have whatever they want or do what they want."

"You have confidence."

ON CURING ADDICTS:

"Some you can cure, some you can't."

"They gotta do it theirself."

This hard wisdom was passed along to professors and psychiatrists working on the drug addiction project at NYU's Research Center for Human Relations.

Eva Rosenfeld, assistant research professor, was sufficiently impressed to mimeograph excerpts for her colleagues with this comment:

"If you recall the summary of our findings on drug users, you will note the striking similarity in these boys' insights and our knowledge. As to the method of rehabilitation, we would only wish that our public officials had the instinctive understanding these boys show."

Research, then, is just beginning to catch up with street lore, theory with practice. Lagging far behind are the law and the lawmakers.

It may come as an awesome discovery for a doctor, a social worker, a Senator or a judge that the "dope fiend" is just another human being. But, for a theologian, it is an article of unchanging faith.

This, perhaps, is why the church is a tentative leader in meeting the problem of addiction in Our Town. In a medico-social area which the government has appropriated as its own and interpreted as almost exclusively legal, the church alone can offer sanctuary.

Even the crypto-religious ideas at the root of Narcotics Anonymous seem foredoomed to failure outside an institutional setting because of the shadow of the law. Major Dorothy Berry of the Salvation Army, a cheerful individualist who is waging a one-woman war against the myths that have been incorporated into drug addiction laws, sums it up out of bitter experience:

"The 12-step approach of Alcoholics Anonymous won't work with addicts unless you could try it in the lobby of the YMCA.

"If a fellow was about to go back on drugs and called a former addict to come to his room to sit with him and help him, the former addict couldn't risk it. The place might be raided and you'd have two fellows in trouble instead of one."

Virtually the only place left then where addicts, former addicts and their relatives and friends can meet in safety is on hallowed ground. There are two such oases in Our Town.

In an eloquent, little volume called "Light the Dark Streets," published by Seabury Press, Rev. C. Kilmer Myers, vicar of St. Augustine's Episcopal Mission on the Lower East Side, tells some of the experiences of his parish in ministering to the addict as well as to the delinquent youth and the gang member.

"We have made many, many mistakes," he writes, "but at least the lines of communication were kept open."

Wherever addicts are regarded as sick people rather than criminals, another church group is cited for valor—the East Harlem Protestant Parish, where the Rev. Norman C. Eddy is doing what has been described as "the best work in town."

Both these programs at present limit their efforts to before-and-after care for addicts who go to a hospital or a jail in search of a cure. But in a church basement in Chicago another Protestant parish has gone beyond anything tried by Myers or Eddy.

There St. Mark's Episcopal Church has established a clinic where addicts receive medical treatment to ease them through the withdrawal period on a voluntary, out-patient basis.

U. S. Narcotics Commissioner Anslinger refers to this kind of treatment as "ambulatory" and insists it is at best worthless, at worst forbidden.

But the St. Mark's program, now known as the Addiction Research Foundation, shows for its two-year

Dr. Marie Nyswander
"She was an Anslinger man . . ."

operation an apparent rate of success beyond the most optimistic claims ever put forth for the federal program by Anslinger himself.

Both patients and staff are volunteers. Father Robert T. Jenks, the chairman, reports that of the 300 Chicagoans (all but 17 of them heroin mainliners) who have patronized the clinic, 25 per cent have remained off drugs for four months or more.

What distinguishes St. Mark's is its attempt at the total approach. "We treat the addict in his own habitat," Father Jenks told The Post. "We think our follow-up program makes the difference between success and failure. We help each person in his own environment, following him into his home and into his job."

Two volunteer physicians direct the medical phase of the program. The tranquilizer reserpine is used, together with a non-barbiturate sleeping medication, to calm the addict during the acute stage of the abstinence syndrome.

Sometimes these mild techniques don't work. A total of 11 men and one woman were found to need in-patient care; another 38 addicts took the pills and never came back. BUT—80 per cent were successfully withdrawn after four days.

Step No. 2 at the Chicago clinic is an effort to get at the root cause—the "anxiety-producing failure"—of which addiction is usually the symptom.

Five clinical psychologists contribute their time and

Extensive interviews and tests are followed by individual or group therapy.

The totally voluntary character of the program serves as a self-screening process. The patients are motivated or they don't come back. Of the 75 per cent who relapse into addiction or make no real effort to kick their habit, Jenks says:

"We keep urging them to come back and try again. We tell them we don't hold their failures against them."

The third phase of the program grapples with the twilight zone of addiction, when physiological withdrawal is complete and self-understanding begins—and the temptation of relapse sets in. Five volunteer social workers cooperate with the medical staff and the church's professional staff to bring the whole gamut of socio-economic problems under scrutiny—jobs, food, shelter, emergency relief.

(It is precisely this feature that New York City's internationally famed Riverside Hospital lacks because of personnel and budget shortages.)

Trusted—or Untouchable?

Pulling the whole St. Mark's operation together is the pastoral phase, in which the church seeks to develop a personal relationship of confidence and trust with each patient in the hope of dispelling the effects of loneliness and rejection.

(Riverside confines itself to addicts under 21; St. Mark's takes all comers. "Actually," Jenks says, "this age differential works on our side. Our average addict is about 27. It is easier to establish a meaningful relationship with him than it is with the teen-agers on whom Riverside has to concentrate.")

Jenks has estimated the temporal value to Chicago of the St. Mark's clinic in the cold-cash terms of prevented crimes against property. He sets this at $108,000, a modest figure that doesn't allow for the avoided cost of detection, apprehension, court hearings, jail and the other expenses of the revolving-door police approach to the addict-turned-criminal.

The clinic, then, has saved Chicago an impressive sum and has earned the right to speak and be heard:

"We especially deplore the present punitive measures directed against the narcotic user," Jenks emphasizes. "We are pressing for legal measures which will deal with this problem in terms of therapy rather than penology."

Here in New York City the addict who drifts into his synthetic paradise on the wings of heroin is still marked untouchable, condemned to crime before he becomes a criminal.

The hospitals won't take him. Doctors, prompted by the Narcotics Bureau, reject him. Social service agencies shrink from him. The one community center that opened its door to adolescent addicts in recent years promptly slammed it shut again: Too little reward, too much danger of contamination.

Newspapers pump fresh printer's ink into flamboyant stories about junkies, periodically updating the standard series on the blood-red petals of the opium poppy and the adventures of heroic narcotics agents.

Everyone talks about drug addiction, but no one does anything about it. There are, however, a few enlightened public servants who are willing to try. They dare at least to say in public what they think in private and their ranks are steadily growing.

Blind Spot

Today they form a kind of unofficial alliance, united in their desire to replace the old-fashioned, rigid, unsuccessful police techniques with more practicable, less punitive measures.

This fraternity looks with interest at the so-called British system of narcotics control and the variations on that theme that are in use in various countries of the Western world.

It is altogether revealing that Anslinger, the commissar of American narcotics enforcement, steadfastly denies the existence of the British system. Daniel might as well have denied the existence of the lion, Jonah of the whale.

The Commissioner, never the man to allow truth to interfere with private fantasy, insists: "The British law is the same as ours." This is true as far as it goes. What Anslinger blinds himself to is the vast difference in interpretation.

"In the United Kingdom," Britain has reported to the UN, "the treatment of a patient [addict] is considered to be a matter for the doctor concerned. The nature of the treatment given varies with the circumstances of each case."

Dr. Kenneth Chapman, a consultant with the U. S. Public Health Service, to whom Anslinger referred these reporters for information on the medical aspects of addiction, said he has seen the British system and is satisfied it works in the British Isles. Whether it could be transplanted to this country, he doesn't know.

"The British do not believe in giving drugs to addicts just to support their addiction," Chapman cautioned. "An eminent British physician said, 'We don't like the fact that you Americans talk of us as filling stations for addicts—our addicts get drugs only if they are sick.'

"Now the difference between the British and the American systems is in the interpretation of 'sick.' Their view of what constitute medical indications for the need of narcotics is broader than ours. In other