

# The Drug Hang Up, America's Fifty-Year Folly

by Rufus King

## Chapter 20

### The British and Other “Systems”

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TROUBLING CHAPTERS in the American story still lie ahead. The nation has scarcely fared better in the decade since Commissioner Anslinger relinquished the reins than during his overbearing incumbency. But at this point let us clear up the mysteries allegedly surrounding the "British System," and then look briefly at policies and problems in the rest of the world.

Obscuring the British experience has long been a major objective of drug-law enforcement forces in the United States, yet nowhere is it easier for American observers, approaching from common antecedents and with no language barrier, to get at the truth. And the truth in this instance is singularly enlightening. For the British story makes much of America's half-century preoccupation with "dope" laughable.

Understandably, the calm prevailing on the drug scene across the Atlantic all these years has been a whole bush of thorns in the sides of Anslinger and his successors. That they have so long succeeded in misleading the American public, and with such crude distortions and deceptions, may have implications about the way the country is governed that go far beyond the compass of this work. Right now, in the early seventies, conservative drug-maintenance proposals in Washington and New York still evoke such official comments as "a phony experiment modeled on the British plan that has become a disaster" or "the entering wedge to get into . . . the plan that failed in England.")

Commencing with their joint promotion of the opium traffic in China, through most of the nineteenth century and, generally, until after the Hague Opium Convention of 1912, England and the United States followed closely parallel courses. Both nations gradually reacted to the spectacle of their citizens growing rich in the exploitation of addiction in the Far East. Both accepted opium smoking in their own societies as an exotic but unimportant fad confined to immigrant Orientals and a few avant-garde figures like Coleridge, DeQuincy, Wilde, and Poe.

There was a slight parting of ways in the response to drug-laden patent medicines: as we have already noted, the British early clapped many such nostrums under controls developed for "poisons," while Yankee lawmakers did virtually nothing about them until well into the twentieth century. Also, controls over pharmacists were imposed earlier and

observed more carefully in England than in the United States. The first British Pharmacies Act was passed in 1852.

Great Britain had been a moving force, along with the United States, in promulgation of the 1912 Hague Convention, and the British Dangerous Drugs Act, passed by Parliament in 1920 to carry out Convention obligations with respect to controlling domestic traffic, was strikingly like the U.S. Harrison Act. Raw opium and opium prepared for smoking were banned: everyone in England handling "dangerous drugs" (heroin, morphine, cocaine, etc.) was required to register, obtain a license, and keep accurate records; pharmacists dispensing such drugs were obliged to keep special prescription files and sales records and to make them available for inspection by the regulatory authorities; physicians were also required to keep detailed records, although this requirement was never vigorously enforced.

The Secretary of State for Home Affairs was given authority to make regulations governing administration of the Act, and it is noteworthy that the regulations he prescribed left open the very ambiguity concerning the rights of physicians which caused so much trouble with the Harrison Act in America. The British regulations exempted from control any person who, being a duly qualified medical practitioner, "shall be authorized, so far as may be necessary for the practice or exercise of his said profession, function or employment, and in his capacity as a member of his said class, to be in possession of and to supply drugs."

Moreover, the Home Office thereupon put out an interpretative ruling which sounded like a strict interpretation indeed:

The authority granted to a doctor or dentist to possess and supply dangerous drugs is limited by the words so far as may be necessary for the practice or exercise of his profession. [*Italics in original.*] In no circumstances may dangerous drugs be used for any other purpose than that of ministering to the strictly medical or dental needs of his patients. The continued supply of dangerous drugs to a patient solely for the gratification of addiction is not regarded as "medical need."

But here the parallel ends. In the United States the Treasury took matters into its own hands and in 1922 won the tricky Behrman mandate from the Supreme Court, thus enabling enforcement agents to tell the medical profession what its rights were. In Britain the solution was entirely different. At the instigation of the government, the Royal Medical Society appointed a committee of eminent doctors, under the chairmanship of Sir Humphrey Rolleston, and in 1924 this committee undertook a careful study of the role of the medical profession and the prerogatives of the medical practitioner with respect to the narcotics addict. Two years later the committee reported its findings to the Home Office, in part as follows:

Precautions to be Observed in the Administration of Morphine or Heroin.  
The position of a practitioner when using morphine or heroin in the

treatment of persons who suffer from addiction to either of these drugs obviously differs in several important respects from that in which he is placed when using the drug in the ordinary course of his medical practice for the treatment of persons not so affected. Not only will the objects of treatment usually differ, but also the dangers to be avoided and the precautions that are therefore necessary. . . .

Morphine or heroin may properly be 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, and (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 Rolleston report then set forth medical precautions to be observed in treating addicts. The doctor was urged to seek a second confirming medical opinion before beginning a narcotics regime. It was suggested that he keep in touch with the Home Office as to the basis on which the patient was being treated, and if he found he had lost control he should bring pressure to induce the patient to enter an institution. With respect to the handling of incurable addicts, the report directed:

Precaution in Treatment of Apparently Incurable Cases. These will include both the cases in which the severity of withdrawal symptoms, observed on complete discontinuance after prolonged attempted cure, and the cases in which the inability of the patient to lead, without a minimum dose, a relatively normal life appear to continuous administration of the drug indefinitely. 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 been previously 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 limit 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.

If an incurable patient was going to be out of touch with the doctor for some period, as on a trip or during the doctor's own holiday, it was urged that only a minimum supply be made available to him and that if possible the patient be temporarily referred to another doctor for continuing care.

For forty years these so-called Rolleston Rules, with the relaxed illogicality that makes British law enforcement the most reasonable and efficient in the world, were, though they

lacked official force, directly appended to and printed with the Home Office Regulations (which say a doctor may not prescribe solely to gratify an addict's habit), so that even though the law and governing regulations remained menacingly narrow, safe limits of good medical practice were expressly spelled out for doctors in England.

British enforcement efforts have always been aimed at reinforcing control by medical practitioners instead of menacing the doctors themselves, as is illustrated in another Dangerous Drug Regulation regarding possession:

. . . a person supplied with a drug or preparation by, or upon a prescription given by, a medical practitioner shall not be deemed to be a person generally authorized to be in possession of the drug or preparation he was then being supplied with a drug or preparation by, or on a prescription given by, another medical practitioner in the course of treatment, and did not disclose the fact to the first-mentioned medical practitioner before the supply by him or on his prescription.

Thus there was created an offense which could only be committed by the addicted person and, in effect, only against the doctor: the offense of defrauding the latter by applying to him as a patient when in fact the patient is already receiving drugs from another doctor. And it is noteworthy that over the years this offense often accounted for as many as half the prosecutions instituted in Great Britain for violations involving manufactured drugs (heroin, morphine, cocaine, and the synthetics).

There has never been anything in the United Kingdom remotely resembling the army of enforcement agents maintained to cope with the drug traffic in the United States. A few police officers are assigned to inspection and enforcement duties under the dangerous drug laws, a score at Scotland Yard covering Metropolitan London, a half dozen in each of England's other large cities like Manchester and Liverpool, and one or two in smaller centers. These officers examine pharmacy records and investigate pilferage, or theft involving drugs. By watching prescriptions, they quickly see if a doctor begins providing unusual amounts or if one patient appears to be receiving unreasonable dosages. When this happens, they do not take any prosecutive steps, but merely report to the Dangerous Drug Branch in the Home Office.

The Home Office is not an enforcement agency, but its Dangerous Drugs Branch, with half a dozen inspectors under a chief, is charged with receiving reports from the police and keeping central records. This unit also receives and maintains reports by medical practitioners of addicts under their care, formerly furnished on a voluntary basis but now required, by a recent change in the law and the regulations, for each individual under treatment.

In England, as elsewhere throughout the world, there is a relatively high incidence of addiction among medical practitioners themselves and in the ranks of other persons whose vocations give them ready access to drugs. But even in these cases, as well as when a doctor is found to be abusing his prerogatives by too large a volume of

prescriptions, the enforcement authorities traditionally would not dream of prosecuting, nor even of addressing the doctor directly with respect to his alleged abuse or offense. Instead, the Dangerous Drugs Branch would refer the matter to the Ministry of Health, which would direct a regional health inspector or a member of a local medical board to call on the doctor and discuss whatever the problem seemed to be.

Criminal actions against doctors have been rare; if the implied warning and reprimand of a visit from a health inspector did not suffice, the ultimate sanction was usually a temporary suspension of authority to prescribe drugs. A doctor who is himself addicted need only place himself under the care of a fellow physician to avoid further difficulties and carry on with his practice while undergoing an attempted cure-or ultimately, if necessary, while he is maintained on a stabilizing regime of drugs.

It is not open to question that with police supervision which has always been excellent though limited, with the vigilance of medical practitioners themselves, and with the supervisory activities of the Home Office inspectors and the Dangerous Drugs Branch, there has never been any very large undetected body of drug addicts, or "invisible" problem, in Great Britain. The British authorities think there may be a few people with ample means who supply themselves privately with drugs from abroad, but not a significant number. They are confident that except under very unusual circumstances every new addict comes to their attention through one or another of their supervisory activities within a matter of months. So the statistical picture has always been in pretty good focus--doubtless clearer than comparable statistics for countries like the United States and Canada where the entire problem has been so long submerged in the underworld.

And what are the statistics? In the 1920's the nonmedical addict population in the United Kingdom is believed to have fluctuated in the low thousands (as the combined U.K. census for England, Northern Ireland, Scotland, and Wales approached the 45 million mark). By 1935 the addict count was reduced to 700, and 120 of those were to be found in the medical profession. During the 1950-60 decade it dipped to the range of 300 to 400 (1960 U.K. population: 52 million). In 1954, for example, the number was 317, of whom 148 were male and 169 female, and among whom there were seventy-two doctors, sixty-nine dentists, two pharmacists, and one nurse. In 1959 the number had increased to 454 (196 men and 258 women), and there were none known to be under the age of twenty, fifty in the twenty to thirty-four age range, ninety-two between thirty-five and forty-nine, and 278 over fifty (plus thirty-four for whom age data were not available).

The slight upward trend noted in 1959 continued, to 470 in 1961, 532 in 1962, and 635 in 1963--and for this the explanation, in part at least, is interesting. In 1957 Lady Frankau, a London physician world-renowned for her work with alcoholics and drug addicts, began treating a few Canadian and American addicts who turned up in London as refugees from persecution at home. This started a small migration, and a few other London doctors began to take on such patients. The number of these addicts who could afford to seek help by self-imposed banishment was pathetically small, but by the middle sixties the total number included in the British rolls was several hundred, with a cumulative total of

about a thousand who had come for treatment, been withdrawn from drug use, and dropped out of the program to be replaced by others. In 1964 the addict population, more than half of it centered in London, was 753, and by 1967 the figure had jumped to 1,729, which will be the subject of further discussion in a moment.

Some idea of British enforcement policies, so different on every count from the hounding, dragnets, and savage sentences with which Americans are familiar, can be obtained by looking at prosecution records. Sanctions available to enforce the Dangerous Drugs Acts have always been substantial. Initially, the maximum fixed by Parliament was two years' imprisonment; then by an amendment in 1951, doubtless in response to the contemporaneous furor in the United States (total U.K. offenses in all drug categories in 1951: 243), maximums were increased to ten years' imprisonment and a 1,000 pound fine-but in practice such penalties have virtually never been meted out in drug cases by British courts. The prosecution option of "summary conviction"-another sensibly informal British institution-reduced maximums in such proceedings to twelve months and R,250 (and the statutes also limited punishment for violations blamed solely on inadvertence to a 250 fine). Prison sentences imposed on addicts for any reason were rare. In the 1950's no more than a dozen addicts per year turned up in the entire British prison system, including those who were committed for all types of offenses and not merely for drug violations. The number is believed to have increased severalfold in the sixties, which still left it at less than 100 new addict-inmates per year.

In 1956, to analyze another sample (this was the year the U.S. Congress passed the Narcotics Control Act, with its life-and-death punishments), there were only 144 prosecutions for violations of the British Dangerous Drugs Act in all the U.K. court systems. Of these, 103 related to marijuana and drew only a handful of sentences, ranging from six weeks' to five years' imprisonment (the latter for large-scale smuggling), and fines from 2 pounds to 250 pounds. Twelve prosecutions were for opium offenses, with sentences ranging from two to six months' imprisonment and fines from 5 to 100 pounds, and twenty-nine were for violations pertaining to manufactured drugs, over half of them prescription forgeries or the offense of seeking a supply from a second doctor when the patient was already under the care of one practitioner. Eight of the manufactured-drug cases involved failure by dispensing persons to keep drugs in locked receptacles, or similar technical violations of the regulations, and in all twenty-nine cases the sentences ranged from one day to six months, with fines from ten shillings to 100 pounds.

By 1966 the prosecution pattern had altered somewhat, chiefly because of the addition of a penalty for unauthorized possession, coupled with a large increase in the number of marijuana charges. Thus in the United Kingdom there were 1,513 drug cases in 1966, with 1,119 convictions for marijuana, including in turn 1,083 for unauthorized possession, ten for smuggling, and seventeen for another new offense permitting premises to be used for smoking or dealing in cannabis. Fines imposed in these marijuana cases ranged from 1 to 1,000 pounds, and prison sentences from one day to five years. The British authorities were also plagued by another new marijuana problem: four cases of domestic cannabis growing were discovered, "involving a few plants grown in gardens." The 1966 convictions in all United Kingdom courts for opium offenses

numbered thirty-six, with fines ranging from 2 to 100 pounds and prison sentences from three to twelve months, while in the morphine-heroin-cocaine category there were 242 convictions, of which 155 were for unlawful possession, thirty-three for unlawful procuring, fourteen for unlawful supplying, and thirty-two for obtaining drugs by larceny or fraud. Fines imposed in connection with the latter (manufactured-drug) offenses ranged from 2 to 100 pounds, and prison sentences from one day to four years.

In the blackout of all nonofficial information about drug policies maintained in the United States by the Treasury Department after 1920, there were astonishingly few references to what was happening in England until Professor Lindesmith began making himself heard in the late 1940's. And from the outset the Narcotics Bureau responded with manic outbursts of denial and denunciation. This was regrettable because there are, in truth, some reasonable considerations which suggest that British attitudes and policies are not a perfect yardstick by which to measure the U.S. problem. Although addiction was common-place and reportedly on the increase in the United Kingdom at the end of World War I, there had been nothing resembling the hysteria that gripped America in that period, and the addiction problem itself was doubtless much smaller because of Britain's better handling of nostrums plus her longer and more complete involvement in the war. Population elements in the two countries are notably different, and it is true that the British, more homogenous and more rigidly stratified, are also generally more law-abiding. Besides which, England had had nothing to launch her on the wrong foot which could be compared to America's off-balance start while simultaneously coping with national prohibition.

But these reasonable distinctions were obliterated by the in-temperance with which Anslinger and his echoers felt obliged to express themselves on the subject. A few typical pronouncements have already been noted, because the "British System" was necessarily a controversial element in the Daniel Committee hearings, in the work of the joint ABA-AMA Committee, and at the NIH Symposium. But the Bureau's counterattacks antedated and continued after those exchanges.

Even elementary regard for consistency seldom operated as an inhibitory factor in the law-enforcement camp. On the one hand, British practices were equated with the other Bureau anathema, the so-called "clinic" experiments of the 1920's, and it was asserted that following the British example would mean handing out drugs without controls and at little or no cost to anyone who was--or wanted to become an addict. On the other, it was vigorously insisted that the problem in England and the way the British dealt with it were essentially identical with the American experience. In 1953 Commissioner Anslinger wrote:

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. . . . 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?

With respect to such rhetorical questions what were the facts?

They were that British seizures of smuggled drugs throughout this period never amounted to more than a few kilograms per year, and that sometimes a full annual reporting period would pass without a single drug theft or attempted theft.

Referring unblushingly to "the present wave of drug addiction" in the British Isles, Anslinger continued this same 1953 argument:

In England, the British Government reports annually only 350 drug addicts known to the authorities—mostly doctors and nurses. When we asked them about the statistics on seizures of opium and hashish (marijuana), 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.

Hashish, of course, is not identical with marijuana, and there is no such thing as "hashish addiction." But in any event, for the years to which the Commissioner referred, the total number of prosecutions for all categories of marijuana offense ranged between 100 and 150.

In 1954 the Bureau, following its customary practice of using official Treasury Department channels and U.S. taxpayers' money to disseminate its views, put out a document entitled "British Narcotic System," aimed specifically at Lindesmith:

Several years ago a professor of sociology at an American university . . . wrote an article in which he advocated that the United States adopt the British system of handling drug addicts by having doctors write prescriptions for addicts. He reported that this system had abolished the black market in narcotics and that consequently there were only 326 drug addicts in the United Kingdom. . . .

Nothing could be further from the truth. 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." The British Government is a party to all of the international narcotic conventions to which the United States is a party.

They enforce treaties in the same manner as the United States. The British and United States systems for enforcing narcotic laws are exactly the same.

The excerpt from the Home Office letter thus officially reproduced is, of course, a perfectly accurate paraphrase of the regulation quoted earlier, and accurate also in the sense that "solely for the gratification of addiction" is a law-enforcement term, not descriptive of medical administration in the United Kingdom or anywhere else.

Commissioner Anslinger, as the U.S. spokesman at the U.N. and with the full prestige of the United States government behind him, could extract statements like the Home Office letter from his official confreres almost at pleasure, and from time to time the Bureau circulated other similarly misrepresentative observations. On one occasion the United Kingdom representative on the U.N. Narcotic Commission provided him with the following:

Dangerous drugs are subjected in the United Kingdom to a wide degree of control and the exacting standard demanded by the inter-national agreements to which the United Kingdom is a party. The indiscriminate administration of narcotics to addicts would be incompatible with those obligations and is not now, and never has been, a feature of United Kingdom policy.

Indiscriminate administration in Great Britain? Of course not. But this was trumpeted as a crushing put-down for American reporters of the English experience.

In 1958, after Mr. Harney had contributed his statement about the Hitlerian "Big Lie" technique, the Bureau circulated what purported to be another letter from an unidentified official in the British Home Office containing the following:

As regards the visits of Americans to this country we are in this difficulty, that it is not possible for us to refuse to have a talk with visiting Americans who asked to be allowed to visit the Home Office to discuss the so-called "British system." However, when we do see these visitors any remarks which we make are rather on the lines of what Mr. Harney has said, and we make it clear that there is not in fact any such thing as a "British system" which is an invention of certain Americans who wish to prove a particular point of view. . . .

The higher consumption of narcotic drugs in the United Kingdom as compared with the United States is in my view mainly a reflection of the fact that we have a free National Health Service.

Higher consumption of drugs in England? Somehow relevant in a discussion of the illicit traffic? Not at all, because what the last statement refers to is simply the fact that British medical practitioners use more morphine (and heroin when it is indicated) as analgesics in connection with their general practice than their intimidated American fellows.

In 1959 Mr. Anslinger came up with a trio of American doctors who seemed eager to chorus his line. Their role in the controversy may be explained by the fact that two of them were public employees of the State of New York (where Attorney General Javits was then propelling himself toward the Senate with a tough-on-dope campaign), while the third was a professor at the state-owned University of Illinois (where Mr. Harney had just been named head of a new Illinois State Bureau of Narcotics). The New York doctors-Larimore and Brill-came back after a month in England to report that there really was no such thing as a British "system," that doctors there had no more freedom to prescribe drugs than in the United States, and that "the opinion prevalent in some quarters that . . . the British system is better than ours" is largely accounted for by misunderstanding. They noted, curiously, that nearly all the British experts with whom they conferred told them that no one else from the United States had ever before been in touch with them (the experts), and that the British were somewhat huffy about any references to a "system," which they thought was an invention by Americans.

The Larimore-Brill team drew large conclusions from small figures: for example, an increase between 1949 and 1956 of from thirty-three to fifty-four drug addicts annually admitted into mental hospitals was characterized by them as "a definite increase"; on the basis of twenty-four addict-inmates among the then total British prison population of 40,000 (three of whom were only marijuana users), they concluded that the British drug addict is a low-level criminal, below the meanest pimp, and that other criminals will have nothing to do with the addict, not only because they don't trust his judgment, but also because they despise him"; and on the authority of a casual reference by one commentator to Notting Hill, the scene of summer riots in London, they alluded to "what appeared to us to be a potentially serious situation from a narcotics standpoint in the Notting Hill section"-where, to their astonishment, no "practical preventive measures" have been employed "to forestall the development of widespread addiction in that area."

Their overall conclusions in 1959 were that the British and U.S. problems were the same and were being approached in the same way and--simultaneously--that the absence of any significant problem in Great Britain was due not to the way controls had been handled, but to the fact that the English "have a definite abhorrence of narcotic drugs." These good doctors revived once more the analogy between drug addiction and infection, this time likening the addict to a typhoid bacillus and characterizing the environment in which he operates as "one contaminated by human wastes to promote the spread of the agent and its introduction into the host."

The Illinois doctor, Ausubel, must have pleased even Mr. Harney. Said he of letting policemen dictate to his medical conferees: "The potentially ruinous consequences of large-scale addiction are so great that control of narcotic drugs cannot simply be left to the discretion of the medical profession." Coming to the British experience by way of the New York Academy proposal, which he termed merely a "clinic" plan, Dr. Ausubel scorned the latter as "excellent Marxism" and "incredibly naive, and said it was based on

a mere fifteen "identifiable logical fallacies and errors of fact." His analogy was to malaria instead of typhoid, with the additional fillip that treating addicts through medical facilities would be like establishing "clinics to dispense jewels free of charge to known jewel thieves." Having thus gathered momentum, Dr. Ausubel sailed head-on into the British:

As if these issues were not already sufficiently complicated, the proponents of legalization and ambulatory treatment have muddied the waters further by injecting the far-fetched analogy of the British system into their arguments. Legally the British system is very similar to our own. . . . The British system, however, has an interpretive joker in it which in practice legalizes lifelong addiction for addicts without appearing to do so in a statutory sentence. . . . The deliberate ambiguity of this legalistic dodge kills many birds with a single stone. . . . Although this practice is the epitome of amoral expediency, it apparently has not led to wide-spread addiction even though the figure of only 359 addicts in the entire British Isles is too small to be credible. . . .

The principal logical fallacy committed by those who advocate the exportation of the British system to the United States is to impute a causal connection between the method of control currently employed and the relatively low rate of addiction. Actually, no such connection exists. . . . Only 0.2 percent of the population in the United Kingdom is of non-Caucasian stock, as compared to 16 percent of the American population. The significance of this difference lies in the fact that two-thirds of the addict population of the United States is recruited from the latter 16 percent.

Because of the much greater number of active and potential addicts in the United States, however, the adoption of the British system would soon create a half a million new addicts without eradicating the illicit market.

In 1965, six years after their first report, Larimore and Brill were sent on another junket to England for the purpose of making a second report to Governor Rockefeller "because of the continued interest and misunderstanding in some quarters here concerning the 'British System.'" They noted-accurately-that the British addiction problem had doubled (from roughly 350 to 700 addicts) and reported a shocking increase in heroin victims, "mostly young males with a smaller admixture of young women, largely prostitutes." They observed that "the addict now plays an active role in the spread of the habit," and that the British were following the U.S. lead in their increasing concern about non-narcotic stimulants and sedatives, although they reported that there had been no increase in the number of addicts in British prisons and that marijuana was not yet thought to constitute a problem of much significance.

Prowling Piccadilly at night, Larimore and Brill observed youthful vagabondage" characterized by "beatnik" types who were unwilling to work, often quite unkempt in

appearance, untrustworthy, unreliable, amoral, manipulative, and difficult. They concluded, in short, that the British approach to the drug problem was now proving to be a total failure with a few additional irrelevancies, such as a notation that the British were "aware of the catastrophic outcome of the recent attempt at a clinic plan in Israel" and a paragraph about how England had tried "clinics" for the administration of drugs unsuccessfully in Asia and Africa prior to World War II (thus chiming in on another Bureau theme, that the success of drug controls in the British Isles ought really to be measured by conditions prevailing under the Union Jack in Singapore and Hong Kong).

The most regrettable thing about this second Larimore-Brill report, distributed all over America with official sponsorship by Anslinger's successor, Henry Giordano, was that there actually had been changes in the British situation which merited consideration. In 1958 the Minister of Health appointed a Review Committee to consider whether modifications should be made in the standards set forth by the 1926 Rolleston Report. The chairman was Sir Russell Brain, from whom the Committee took its name. In November 1960, after extensive study and hearings, the Brain Committee made its report, concluding that no noteworthy difficulties had arisen from the policy of permitting doctors to provide drugs to known addicts, that the few irregularities which had come to light over the years did not warrant regulatory changes to correct them, that the problem of addiction was still "a small one," and that although there had been an increase in the use of cannabis it could not be classified as an addicting drug and required no special administrative measures as of that time. The Brain Committee's principal suggestion was that the Home Office Memorandum which contained the Rolleston Rules "could be presented in a more readable form."

But this first Brain Report came just when the influx of addicts from Canada and the United States was beginning to hit London, and soon thereafter the hippie movement started to grow in England, especially in London, where it seemed to have more vitality than parallel trends in the United States. And though not justifying the exultant cries raised by hard-line U.S. narcotic authorities, there is no question that some new problems did appear to plague the British. Three or four London doctors, possibly as many as half a dozen, began to prescribe heroin in large amounts, defying the gentle sanctions which had theretofore sufficed to hold the medical profession in line. Marijuana smoking jumped alarmingly. Abuse of the amphetamines and barbiturates became more widespread, and the British press, doubtless once more reflecting somewhat the American excitement over the same subject (a story which awaits us in a future chapter), began giving these substances increased attention.

Some observers say Parliament is more sensitive to its electorate than the American Congress. Be that as it may, in 1964 the British lawmakers responded with two new Acts: a new Dangerous Drugs Act, expanding the list of controlled substances, renaming "Indian hemp" cannabis, and creating the new offenses of growing cannabis or permitting it to be smoked in one's premises; and the Drugs (Prevention of Misuse) Act, establishing for the first time a statutory penalty-up to two years-for unlawful possession of abusable substances (in narrow categories covering, at the outset, only some of the amphetamines), setting up a tighter import-license system, and broadening the search and seizure powers

of drug-law enforcers. These 1964 measures, and particularly the cannabis offenses and possession penalties, account for the jump in numbers of prosecutions which we have already noted.

Simultaneously, the Minister of Health reconvened the Brain Committee, requesting its members to consider whether, in the light of recent experience, the advice they gave in 1960 in relation to the prescribing of addictive drugs by doctors needs revising and, if so, to make recommendations." The Committee reported a second time in July 1965, acknowledging a "disturbing rise in the incidence of addiction to heroin and cocaine, especially among young people," and observing that the main source of supply had been reckless prescribing by a small number of doctors. The Committee's report urged, accordingly, that restrictions be imposed on the powers of doctors to prescribe heroin and cocaine and that the system of reporting addicts to the Home Office, which had theretofore been voluntary, be made mandatory by statute. Moreover, the Committee suggested the establishment of a number of "special treatment centres," particularly in the London area, and compulsory detention of addicts, when necessary, in these centers.

In the Dangerous Drugs Act of 1965, Parliament consolidated the 1964 law with earlier measures and further tightened controls on imports. Two years later, in the Dangerous Drugs Act of 1967, the British lawmakers further responded to the Brain recommendations by authorizing the Secretary of State for Home Affairs to limit the power of doctors to prescribe drugs and by setting up procedures to refer disciplinary cases to a special tribunal established by the Act for that purpose.

Under these powers, the Home Office and the Ministry of Health promulgated regulations restricting the authority to prescribe heroin and cocaine to doctors holding special licenses, and have subsequently used this licensing power to channel the prescribing and dispensing of these drugs through hospital centers (there are currently fifteen in the London area, one in Portsmouth, and one in Birmingham) and through a small number of specially licensed practitioners in other parts of the United Kingdom. As the new control patterns took effect, more and more addicts appeared at the centers, and it is not unlikely that the total number of users of heroin (morphine and synthetics were not similarly controlled) might have passed the 3,000 mark at its peak in 1969-70. It is also true, indisputably, that many of these new addicts were young people seduced by Britain's first real drug subculture. Abuse of amphetamines, including "main-lining" methedrine, became popular enough to attract notice and led to a voluntary agreement among doctors, pharmacists, and hospitals not to give out these drugs in injectable form.

There is general agreement, nonetheless, that true addiction (including a swing from heroin to morphine and methadone), serious abuse (heavy use of cocaine, amphetamines, and barbiturates), and the widespread practice of mixing drugs in large doses leveled off in the United Kingdom in 1970, if it did not actually start declining. Pot smokers apart, the drug-involved element seemed to stabilize in the range of no more than a few thousand; there was a decline in new applicants for treatment at the centers, and by early 1971 medical authorities began to feel that they had brought the situation under control.

But the momentum of press-generated excitement and political byplays could not be wound down so easily. The Advisory Committee on Drug Dependence, led by Sir Edward Wayne after Lord Brain's demise, carried on with more studies and recommendations, though generally counseling restraint:

Behind some criticisms that we heard of the law we sensed resentment that users of cannabis should be subject to the same criminal procedures as other drug-users, and a wider doubt as to whether in order to check some forms of drug misuse a sledge hammer had been employed to crack a nut. The balance here between law and liberty is not easy to get right. . . .

The problem presented to society by the misuse of drugs is a serious one. But it is not so serious as to justify what is, for practical purposes, the removal of all rights for the protection of individual privacy from a substantial section of the population.

In 1970 the Labor government proposed a new, comprehensive measure which died in Parliament when the Conservatives took over following the June general elections. The Conservatives thereupon picked up most of the same features, however, and in May 1971, their Misuse of Drugs Act, replacing all anti-drug legislation that had preceded it, became law. The penalty for trafficking offenses is now a maximum of fourteen years, plus an innovation that currently fascinates lawmakers on both sides of the Atlantic: an unlimited fine. Three classifications of drugs, subject to reclassing, by the Home Secretary, determine the gradation of penalties for possession: for Class A, including all the major addicting and abused substances, seven years; for Class B, where cannabis is placed with substances like codeine, five years; and for Class C, borderline drugs and compounds, two years-with, in all cases, the unlimited monetary punishment as well. The summary-conviction option is also retained, however, providing alternatives of twelve months/ 400 pounds, six months/ 400 pounds, and six months/ 200 pounds for classes A, B, and C, respectively.

In announcing the new law, the government was self-laudatory for its leniency in cutting the marijuana penalty in half-from the prior ten years and 1,000 pounds to five years and a fine without limit.

The longstanding statutory protection for doctors and other prescribers acting in good faith in the practice of their professions was virtually wiped out by this Act. The Home Secretary may now specify what are approved prescribing and dispensing practices by regulation. He may also impose special restrictions on particular drugs, like the present heroin and cocaine licensing requirements. Provision is made for a permanent Advisory Council and an Expert Committee to advise the Secretary, and new disciplinary procedures for errant physicians are spelled out. The stringent search, seizure, and arrest provisions of prior Acts are retained and made applicable to all drug-law enforcement. Noting that the British Medical Association appeared to approve every one of these police-oriented encroachments on its prerogatives, an articulate actor on the scene (Hon. William Deedes, M.P.) was constrained to write: "How fortunate are the shepherds of such a docile flock."

And that brings the British story up to date, except for a look at what-after all this, in 1971-Attorney General Mitchell has to say on the subject:

Some have said, "Let's legalize the possession of drugs and provide them free under a doctor's care." According to this argument the addicts won't have to steal to get money for dope. And by taking the profit out of the illicit traffic the pushers would go out of business.

This is the approach taken in Great Britain, and in the opinion of our observers it is proving to be wrong. The dope pushers have moved into Britain in a big way, and are providing narcotics to the addict over and above what he receives through medical care. And there is a tendency of pushers and addicts alike to spread the disease. So what I would call the "surrender" approach-hasn't proved itself.

The official response to this in London, where it caused a mild furor, was that Mitchell was making "a 'political' speech strictly for domestic consumption." The less official characterization from medical and legal commentators was reduced by the London Times to a single word: "Rubbish!"

It is too early to assess the effects of the 1971 Misuse of Drugs Act. The British do not lose their perspective easily. But if the situation does worsen in their new drift toward tougher laws, more aggressive regulation, busier police, and meeker doctors, it must not be overlooked that what is really happening is that they are at long last toying with features characteristic of what could be called the "American system."